Whole Person Care Agreement
Attachment A

City and County of San Francisco
Whole Person Care Pilot

Application to the California Department of Health Care Services

Originally submitted July 1, 2016
Approved November 16, 2016

Legacy Lead Entity Pilot Expansion, Submitted March 1, 2017

Revised 05/19/17

SECTION 1: WPC LEAD ENTITY AND PARTICIPATING ENTITY INFORMATION

1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.b.i)

Organization Name	San Francisco Department of Public Health (SFDPH), which includes Zuckerberg San Francisco General Hospital
Type of Entity	Designated Public Hospital
Contact Person	Barbara A. Garcia
Contact Person Title	Director of Health
Telephone	415.554.2526
Email Address	Barbara.Garcia@sfdph.org
Mailing Address	101 Grove, Ste. 308, San Francisco, CA 94102
Add'l Contact Person	Maria X. Martinez
Add'l Contact Person Title	Director of Whole Person Care
Add'l Contact Person Telephone	415.554. 2877
Add'l Contact Person Email	Maria.X.Martinez@sfdph.org

1.2 Participating Entities

Required Organizations	Organization Name	Contact name and title	Entity description and role in WPC
1. Medical Managed care plan	San Francisco Health Plan (SFHP)	Sumi Sousa, Officer, Policy Development & Coverage Programs	The San Francisco Health Plan is the public, not for profit Medi-Cal managed care plan for the City and County of San Francisco and currently enrolls 86% of the city's Medi-Cal managed care members. SFHP was created by the City and County of San Francisco and is governed by a 19 member board made up of SFHP members, providers, labor and representatives from the Mayor's Office and Board of Supervisors. SFHP is committed to improving the quality of life for the people of San Francisco and the providers who serve them. The San Francisco Department of Public Health is the largest provider of care for SFHP's Medi-Cal members, with over 40% assigned to their primary care clinics or where San Francisco General Hospital is their designated hospital.

Required Organizations	Organization Name	Contact name and title	Entity description and role in WPC
			Under the WPC Pilot, SFHP will be a data-sharing partner as well as a member of the Steering Committee. SFHP will provide WPC pilot partners with all relevant member information, including utilization data and access to PreManage Community, an information exchange that provides real-time alerts to primary care providers from hospitals and an editable, interactive care plan. SFHP will also ensure that its participation in the WPC Pilot is aligned and coordinated with SFHN's work on PRIME and SFHP's upcoming Health Homes pilot. Other WPC care partners will provide relevant information back to SFHP so that there is no duplication but instead, a more efficient, effective care delivery system.
2. MediCal Managed Care plan	Anthem Blue Cross Partnership Plan	Joel Gray, Executive Director, CA Medicaid North	Anthem Blue Cross has more than 25 years of experience administering Medicaid and state-sponsored programs in California, during which they have developed long-term, collaborative partnerships with the State and many counties. Anthem currently provides services to over 1.2 million Medicaid members throughout California. Services are provided on a foundation of accountability and responsibility to members with a person-first philosophy, which includes focusing on the many social and physical determinants of health that impact the Medicaid population. Under the WPC Pilot, Anthem will be a data-sharing partner as well as a member of the Steering Committee. Anthem will participate in WPC Pilot planning activities, identification and engagement of members, and coordination efforts. Data will be exchanged bi-directionally between Anthem and the WPC Partners to ensure eligible members are referred to programs that best meet their needs without duplication of services.They will additionally share health outcome and

Required Organizations	Organization Name	Contact name and title	Entity description and role in WPC
			utilization data for purposes of program evaluation.
3. Health Services Agency/Department	San Francisco Department of Public Health (SFDPH)	Maria X Martinez, Director of Whole Person Care	The San Francisco Department of Public Health (SFDPH) is the lead entity and health care anchor for San Francisco's WPC Pilot. The Mission of SFDPH is to protect and promote the health of all San Franciscans. SFDPH strives to achieve its mission through the work of two main branches – the Population Health Division and the San Francisco Health Network (SFHN). With a broad community focus, the Population Health Division provides the core public health services for the City and County of San Francisco, such as health protection and promotion, disease and injury prevention, disaster preparedness and response, disease surveillance and monitoring, and environmental health services. SFHN is the City's only complete system of care and has locations throughout the city, including Zuckerberg San Francisco General Hospital Medical Center, Laguna Honda Hospital and Rehabilitation Center, over 15 primary care health centers, and a comprehensive range of substance abuse and mental health services. As the City's safety net system, SFHN serves more than 100,000 people every year through its clinics and hospitals and serves the largest percentage of the city's Medi-Cal beneficiaries and uninsured. Under the WPC Pilot, SFDPH will be the lead entity, a data sharing partner, a Steering Committee co-chair, and a service provider. As the lead entity responsible for coordinating the WPC Pilot, SFDPH will provide project management, submit all reports, convene meetings, monitor services, and develop, implement and monitor the budget. SFDPH will work with its WPC Pilot partners to

Required Organizations	Organization Name	Contact name and title	Entity description and role in WPC
			develop policies and procedures related to the pilot. SFDPH will provide primary care and behavioral health services through SFHN, and ensure that the WPC Pilot aligns with other efforts, including PRIME, Health Homes, and the Drug Medi-Cal Organized Delivery System. SFDPH maintains the Coordinated Case Management System database, which centralizes essential health, behavioral health, and social information on homeless adults accessing public healthcare services. Relevant CCMS data will be shared with other WPC Partners that will likewise share their client data with SFDPH to provide a real-time, actionable whole person profile.
4. Specialty Mental Health Agency/Department	San Francisco Health Network (SFHN) Behavioral Health Services (BHS)	Kavoos Ghane Bassiri, Director, Behavioral Health Services	San Francisco Behavioral Health Services (BHS) is a part of SFDPH's health care delivery system, the San Francisco Health Network (SFHN). BHS operates the County Mental Health Plan, Jail Behavioral Health Services, and provides San Franciscans with a robust array of services to address mental health and substance use disorder treatment needs. The full range of specialty behavioral health services is provided by a culturally diverse network of community behavioral health programs, clinics and private psychiatrists, psychologists, and therapists. Treatment services include: early intervention/prevention, outpatient treatment (including integrated medical and behavioral health services), residential treatment, and crisis programs. Services are integrated, trauma informed, culturally competent, and based in principles of recovery and wellness. Treatment sites are located throughout San Francisco and services are available to residents who receive Medi-Cal benefits, are San Francisco Health Plan members, or other

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			San Francisco residents with limited resources. Under the WPC Pilot, SFHN BHS will be a provider of mental health and substance use disorder services as well as a data sharing partner (to the extent allowed by law). A significant number among San Francisco's homeless population have behavioral health challenges. SFHN BHS and the Mental Health Plan provide a multitude of services that will benefit the WPC pilot target population, including placement, hospitalization/stabilization, and outpatient services. BHS operates a Behavioral Health Access Program that will serve as an entry point for individuals with mental illness, and appropriately prioritize WPC Pilot clients into lower levels of care. BHS will also be integral in guiding the creation of the Behavioral Health Navigation Center.
5. Public Agency	Department of Homelessness and Supportive Housing (HSH)	Kerry Abbott, Deputy Director for Programs	The consolidated Department on Homelessness and Supportive Housing (SFHSH) launches as the newest City and County of San Francisco (CCSF) agency on July 1, 2016. With the singular focus on addressing homelessness in San Francisco, it is made up of essential homeless serving programs that traditionally existed in other departments across city government. SFHSH's services range from homelessness prevention and street outreach, to shelter, to supportive housing. By moving these programs under one roof, HSH will increase coordination and improve services through an integrated *Navigation System* that will match people with the right housing interventions based on their specific needs. Under the WPC Pilot, SFHSH will be a data sharing partner, a Steering Committee co-chair, and a service provider. As the CCSF agency tasked with serving and housing the

Required Organizations	Organization Name	Contact name and title	Entity description and role in WPC
			homeless, SFHSH will work with its WPC partners to build the communications, data and technology infrastructures needed to create the Multi-Agency Care Coordination System, while ensuring consistency and alignment with SFHSH's development of coordinated entry for housing placement. SFHSH has been deeply involved in the planning for WPC and will be integral in the implementation of the initiative.
6. Public Agency	Human Services Agency	Susie Smith, Deputy Director, Policy & Planning	The Human Services Agency (HSA) comprises three City and County of San Francisco departments: the Department of Human Services (DHS), the Department of Aging and Adult Services (DAAS), and the Office of Early Care and Education. HSA serves as the state-mandated county public social services agency, providing public assistance to low income children and families, single adults, the disabled, and seniors in San Francisco. HSA provides cash assistance, food and nutritional support, health insurance, employment training, child care subsidies, in home care, among other services. In addition, HSA provides services and support to children, seniors, and dependent adults. Until the recent creation of a new department exclusively focused on homelessness and supportive housing, HSA also administered the City's homeless and supportive housing services and brings significant expertise in homeless services. Under the WPC Pilot, HSA will be a data sharing partner, a Steering Committee member, and a service provider. HSA will ensure that participants in the WPC Pilot receive all of the public benefits for which they are eligible, as well as help connect clients who enter through its service doors to other city resources. HSA will help WPC Pilot

Required Organizations	Organization Name	Contact name and title	Entity description and role in WPC
			participants enroll and remain in: Medi-Cal, CalFresh (SNAP), CalWORKS (TANF), and the County Adult Assistance Programs (CAAP), which provides short-term cash aid and social services to very low-income San Franciscans with no dependent children who are not eligible for other cash assistance programs. CAAP also helps low-income, able-bodied adults access employment and training opportunities through the Personal Assisted Employment Services program. For elderly and disabled adults, the program provides additional cash aid and assistance in applying for Supplemental Security Income.
7. Public Agency	San Francisco Department of Aging and Adult Services (DAAS)	Cindy Kauffman , Deputy Director	San Francisco's Department of Aging and Adult Services (DAAS) plans, coordinates, and advocates for community-based services for older adults and adults with disabilities. The mission of DAAS is to assist older adults and adults with disabilities, and their families, to maximize self-sufficiency, safety, health and independence so that they can remain living in the community for as long as possible and maintain the highest quality of life. DAAS coordinates an integrated, comprehensive range of social, mental health, and long-term care services that fosters independence and self-reliance. Under the WPC Pilot, DAAS will be a data sharing partner, a Steering Committee member, and a service provider. DAAS has been integrally involved in the planning and development of the WPC Pilot and is highly invested in the development of IT-infrastructure that will enable coordination of services and sharing of data throughout city and community programs. The WPC pilot will further enhance and enable DAAS to provide wraparound services through case management and coordination for older

Required Organizations	Organization Name	Contact name and title	Entity description and role in WPC
			individuals who enter the program via community providers.
8. Community Partner	Institute on Aging (IOA)	Dustin Harper, Vice President of Community Living	The Institute on Aging (IOA) is one of Northern California's largest community-based nonprofits providing comprehensive health, social, and psychological services for seniors and adults with disabilities and chronic illness. IOA's mission is to enhance the quality of life for adults as they age by enabling them to maintain their health, well-being, independence, and participation in the community. IOA develops and provides innovative programs in physical health, mental health, social services, education, and research. Their patient population is highly diverse across race and ethnicity, primary language, gender, socioeconomic status, and psychiatric diagnosis. IOA offers 24 programs and services that reach over 8,000 unduplicated individuals each year across the Bay Area. IOA holds home care, community clinic, and adult day program licenses, and provides social, recreational, mental health, educational, care management, home care, fiduciary, and community support services. Since 2007, IOA has worked with DAAS to administer the Community Living Fund, which funds home and community-based services, or combination of goods and services, that help individuals who are currently, or at risk of being, institutionalized. The program targets some of California's highest utilizers and uses a two-pronged approach: (1) coordinated case management and (2) purchase of services. Under the WPC Pilot, IOA will be a data sharing partner, a Steering Committee member, and a service provider. IOA will provide services that increase the quality of life for WPC clients through enhanced care

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			delivery and the provision of services that foster independence.
9. Community Partner	HealthRIGHT 360 (HR360)	Vitka Eisen, CEO	HealthRIGHT 360 (HR360) is a non-profit 501(c)3 organization that in 2011 combined the legacy of the nation's first free medical clinic (Haight Ashbury Free Clinic, founded in San Francisco, 1967) and the expertise of a leading behavioral health organization (Walden House, founded in San Francisco, 1969) into a comprehensive, integrated Federally Qualified Health Center. The agency has grown in recent years following a series of visionary mergers across California that anticipated the whole-person-health and integration aims of healthcare reform. Today in San Francisco, HR360 operates four primary care health centers and over twenty behavioral health programs that are specialized to address the needs of specific sub-populations (including women with children, individuals at high risk of HIV/AIDS, seriously mentally ill offenders, and transgender individuals), and they provide full-spectrum, integrated care to low-income, homeless, and/or justice-involved adults, children, and families. HR360 also specializes in providing substance use treatment services. An overwhelming number of homeless adults suffer from substance use disorders. HR360 will integrate substance use disorder treatment services across the WPC Pilot programming aimed at improving health outcomes for people experiencing homelessness. Under the WPC Pilot, HR360 will be a data sharing partner, a Steering Committee member, and a service provider.
10. Community Partner	Baker Places	Jonathon Vernick,	Baker Places is a San Francisco community based agency established in 1968 to provide

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		Executive Director	transitional residential treatment services as an alternative to long term care in state hospitals. Today Baker operates 9 treatment programs scattered throughout the City that focus on individuals with mental health, substance abuse and HIV/AIDS related issues. It operates the only medically managed Detox in the state and its programs offer a continuum of care from acute and transitional licensed, residential treatment services as well as supported housing with case management. Many among the population served by Baker have had episodes of homelessness in their recent past. Baker Places will provide an enhanced continuum of care to the WPC Pilot participants, including extended residential treatment stays for the participants until they are connected to appropriate supportive housing and wrap around services. Under the WPC Pilot, Baker Places will be a data sharing partner, a Steering Committee member, and a service provider.

1.3 Letters of Participation and Support

Please see attached addendum.

SECTION 2: GENERAL INFORMATION AND TARGET POPULATION

Section 2.1 Geographic Area, Community and Target Population Needs

Overview

Homelessness continues to be an intractable problem in the City and County of San Francisco. Despite spending $160 million dollars per year in homelessness-related urgent healthcare costs, outcomes for San Francisco's homeless population have remained relatively unchanged over the past decade. A deep look into San Francisco's system of care reveals a strong and wide foundation of services and robust data about the homeless population, but also a siloed and uncoordinated service delivery structure with limited capacity to share information. Building upon the system's strengths to overcome these barriers, San Francisco's Whole Person Care Pilot program (WPC Pilot) comprises two key elements: Innovations in Infrastructure and Innovations in Service.

San Francisco Whole Person Care Pilot	**Innovations in Infrastructure**	The **Multi-Agency Care Coordination System** (MACCS) will: o Establish a data sharing platform that can be used as both a real-time care management tool that links information across agencies and disciplines and an integrated data system for analysis and monitoring; o Develop and implement a multi-agency universal assessment tool to evaluate the needs of each homeless San Franciscan; o Use data to strengthen care coordination by stratifying the population based on risk and prioritizing those with the greatest needs for the deepest interventions; o Provide a foundation for a citywide Navigation System, which aligns shelter and housing resources and creates system-wide priorities and data to match people in need with the right housing intervention.
	Innovations in Service	Focusing on homeless adults in San Francisco who rely on the public healthcare safety net, innovative service interventions will: o Maximize use of existing services; and o Create new services that fill identified gaps, largely in the area of behavioral health.
	Budget	PY1: $23.6million PY2: $29.850 million/year PY3-5: 36.1million/year

Strong Service Foundation

The San Francisco Department of Public Health (SFDPH), which operates San Francisco's public healthcare delivery system, is the designated lead entity for the WPC Pilot. Operationally, this responsibility will be shared by SFDPH and the San Francisco Department of Homelessness and Supportive Housing (SFHSH). Together, these two departments represent the strong service foundation upon which this application builds.

SFDPH operates San Francisco's only complete healthcare delivery system. As the public healthcare safety net, SFDPH serves more than 100,000 people annually through its network of 15 primary care clinics, two hospitals, and a wide array of behavioral healthcare (mental health and substance use disorder treatment). SFDPH serves the largest proportion of San Francisco Medi-Cal beneficiaries and uninsured. SFHSH brings together under one roof the multitude of homeless services including engagement, shelter, support services, and permanent supportive housing.

Robust Data

Several data sources provide a picture of San Francisco's homeless population. The 2015 bi-annual point-in-time survey (which enumerates sheltered and unsheltered homeless individuals seen in one night) counted approximately 6,500 homeless individuals, a number that has remained relatively steady since 2005. In 2015, 18% of homeless individuals surveyed cited alcohol or drug use as the primary cause of homelessness, second only to a lost job.

SFDPH's pioneering Coordinated Care Management System (CCMS) database provides important information about homeless adults accessing public healthcare services. CCMS centralizes essential health, behavioral, and social information into a "whole person" profile. The CCMS database currently consists of 61,000 unique individuals who were at one time known to be homeless and received at least one SFDPH service dating back to fiscal year 1997-98. CCMS data reveal, among many things, that this population has high rates of substance use disorders, mental illness, and serious medical conditions, or any combination thereof, and use urgent and emergent services at a high rate.

Timing is Right to Make Meaningful Change

San Francisco is at a critical juncture to make the most of the WPC Pilot. All of the ingredients for success on ending homelessness for thousands of San Franciscans are converging at this time and it will require cooperation like never before. In December 2015, San Francisco Mayor Edwin Lee announced the creation of SFHSH, which launched in July 2016. Among other things, SFHSH is charged with developing a new Homeless Management Information System (HMIS) that provides coordinated entry into San Francisco's homeless shelter and housing programs; MAACS will support and complement this work to address homeless health and service needs. Through the WPC Pilot, San Francisco seeks to build a strong collaborative infrastructure to better integrate our homeless services and programs across agencies.

In addition to the significant opportunities for change in San Francisco's homeless services, the WPC Pilot leverages other health improvement efforts to ensure maximum impact and minimum duplication of services. The WPC Pilot proposal has been designed to complement San Francisco's planning for and participation in the PRIME, Drug Medi-Cal, and Health Homes programs. To ensure coordination and avoid overlap with the Health Homes program, the MACCS data-sharing infrastructure to be developed under the WPC Pilot will be linked to the information technology tool being used by San Francisco's Medi-Cal managed care plans for that program. The alignment of these opportunities places San Francisco in a key position to create a foundation for sustainable success that can support communication and coordination across the delivery system beyond the conclusion of the pilot, and provide a model that can be replicated for success in other jurisdictions.

Developed with Key Partners

To plan for San Francisco's WPC Pilot, SFDPH convened several San Francisco city departments – the incoming staff of SFHSH, the Human Services Agency, the Department of Aging and Adult Services (a division of the Human Services Agency), and the Mayor's Office. Non-city agencies engaged in discussions included both of San Francisco's Medi-Cal managed care plans and several community-based organizations, including HealthRIGHT 360, Baker Places, and the Institute on Aging. We met regularly in the 45 days leading up to the due date of this application to together design the interventions that will have the most significant impact on the target population.

Section 2.2 Communication Plan

San Francisco is in the unique position of recently launching its new Department on Homelessness and Supportive Housing (SFHSH). The strategic planning process for the new department will be critical for WPC implementation and will inform the WPC Pilot's Plan-Do-Study-Act (PDSA) cycles. As the new SFHSH takes shape, the WPC Pilot infrastructure will evolve into a shared governance model, with SFDPH and SFHSH sharing leadership.

At the WPC Pilot outset, a memorandum of understanding (MOU) will be developed that defines and outlines roles, expectations, service integration, deliverables, data sharing, funds flow, patient flow, and terms of participation for all involved entities. The MOU will ensure frequent and clear communication, and mutual understanding among the participating organizations regarding roles, responsibilities, and commitments required for successful pilot implementation. Multiple individuals and committees will be involved in developing and sharing communications among the WPC Pilot participants, as described below.

A dedicated Program Director has been hired as the main contact and the day-to-day operations lead for the WPC Pilot. The Program Director will work directly with care coordinators, partner organizations, and community groups. The Program Director will have responsibility for overall program monitoring and management, providing for partner training in policies and protocols, including the PDSA process, and ensuring

compliance with WPC Pilot requirements. The Program Director will be accountable to the WPC Steering Committee co-chairs.

A WPC Steering Committee has been established to provide policy-level oversight of the WPC Pilot. Co-chaired by SFDPH and SFHSH, the WPC Steering Committee will meet monthly and comprise executive-level representatives with decision-making authority on behalf of each of the partner organizations, which include the community based organizations, Medi-Cal managed care plans, and other city departments working on WPC. They will provide strategic guidance, review and approve policies, and direct service, clinical, operational and information technology integration. Members of the Steering Committee will represent the WPC Pilot in public forums. Finally, the Steering Committee will help identify trends across the pilot that may provide for improvement through PDSA, and resolve strategic and policy barriers that arise from the WPC Operations Committee.

A WPC Operations Committee will be established to oversee the seamless delivery of care to participants and smooth communication across the direct services teams in the partner organizations. Accountable to the WPC Steering Committee, the WPC Operations Committee will meet twice monthly and comprise service providers, clinical staff, consumers, and other partners. It will have purview over functional elements of the WPC Pilot through a series of subcommittees (these may include performance improvement, budget, patient care, information technology, data sharing, and others). Importantly, the WPC Operations Committee will be responsible for performance improvement through PDSA cycles.

The WPC Program Director will be responsible for managing two key communications tools: a bi-monthly WPC Pilot Program update, supplemented by emails as needed, to connect the Steering Committee, the Operations Committee, and its subcommittees; and a bi-monthly program update to communicate to outside stakeholders, program participants, and the community at large. The committees are meeting at least once monthly, so they will also receive program updates at each of these meetings. The WPC Pilot will leverage its partners' communications platforms (e.g., newsletters, websites) to broaden its communications reach.

Section 2.3 Target Population

San Francisco's WPC Pilot will focus on Medi-Cal enrolled homeless adults. In FY 2014-15, SFDPH's CCMS data repository identified 9,975 homeless individuals who had received public healthcare services through SFDPH. Approximately 6,700 of these individuals would be Medi-Cal beneficiaries eligible to participate in the WPC Pilot – 5,000 are known Medi-Cal Managed Care enrollees and an additional 1,700 are Medi-Cal Fee-for-Service beneficiaries. While CCMS data show that a higher proportion would potentially be Medi-Cal eligible (due to low income), given the challenges facing this population, it is likely that not all Medi-Cal eligible individuals will actually enroll in Medi-Cal.

In early 2016, SFHSH conducted a modeling project that revealed there are a significant number of homeless individuals who are either not in SFDPH's integrated data system,

Coordinated Care Management System (CCMS), or are not accurately identified as homeless in their CCMS record using HUD point-in-time data, Homeless Management Information Systems (HMIS) data, and shelter reservation data. Based on this exercise, we project that nearly 7,000 single adults experience homelessness annually in San Francisco, but were not identified in the Round 1 application. Based on our knowledge of the proportion of CCMS-identified homeless persons who are Medi-Cal eligible, in Round One, San Francisco planned to serve 6,700 WPC individuals per year. In Round Two San Francisco plans to serve an additional 4,156 individuals per year with a total of 16,954 unduplicated WPC members served by the end of the program in 2020 including projections from Round One and Two.

We anticipate that we will enroll as many as 6,234 additional unique WPC members by the end of 2020 beyond the CCMS prediction of 10,720 unique WPC members served for a total of nearly 17,000 unique individuals served over the life of the project. We calculated this number based on observations of real data from our CCMS database, which reveal a somewhat constant number of unique homeless persons in San Francisco each year due to an equal number of newly homeless people coming into the city as are leaving (due to leaving the city and county of SF, death, lost to follow-up, permanently housed, etc.) in the calendar year. CCMS data indicate an approximate retention rate of 80% and attrition rate of 20%. Therefore, we expect to add an additional 4,156 members in the second half of PY2 (when the expansion funding begins). In PY3, we expect to lose 1756 members, while retaining 7,022 (80%) from PY2. We also anticipate gaining an additional 3,834 (1,340 + ((1/2(4,156) + .2(2,078)) members in PY3. Finally, we expect 2,171 members to leave in each PY4 and PY5 and 2,171 new members to enter in each PY4 and PY5. Thus, we expect to serve a total of 10,856 persons a year and accounting for attrition and new members each year, nearly 17,000 over the life of the project.

Using this methodology, we expect approximately 2,171 of the previously identified and newly identified eligible participants to disenroll from the Pilot each year, but we also expect the same number of new enrollees each year. The table below provides a breakdown of these estimates.

	PY2 2017	**PY3 2018**	**PY4 2019**	**PY5 2020**	**Total # of unique beneficiaries served across 4 years**
# of WPC Pilot Medi-Cal beneficiaries remaining from prior year	-	**7,022**	**8,685**	**8,685**	

	PY2 2017	PY3 2018	PY4 2019	PY5 2020	Total # of unique beneficiaries served across 4 years
# New WPC Pilot beneficiaries	**8,778***	**3,834****	**2,171**	**2,171**	**16,954**
# of WPC Pilot beneficiaries served in Program Year	**8,778**	**10,856**	**10,856**	**10,856**	

*Only capture ½ a years' worth of newly identified WPC members in PY2 since new funding does not begin until July 1, 2017.

**Because of the above (*), we expect to add a greater number of NEW WPC members in PY3 than in PY4 or 5.

CCMS tracks information across multiple domains, including physical and behavioral health and living situation, and integrates information from multiple systems, including SFDPH's electronic medical record, ambulance transports, jail health services, sobering center, medical respite, behavioral health programs, homeless engagement, and homeless shelters. Of the 9,975 individuals who experienced homelessness during FY14-15 and accessed care at SFDPH:

- More than half have been treated for serious mental health disorders;
- Nearly 60% had a history of drug or alcohol abuse;
- Nearly half have been treated for serious medical conditions;
- A third are tri-morbid and have been treated for all three of the above conditions;
- One-third have been continuously or intermittently homeless for longer than a decade (up from 9% in 2007); and
- Many are aging on the streets (the number of individuals age 60 or older increased 30%, from 856 in 2007 to 1,103 last year)

CCMS additionally has the capability to stratify the population on a range of factors to help prioritize sub-populations for targeted intervention. The WPC Pilot proposes to implement the risk stratification methodology depicted in the table below. We assume that the additional population not in CCMS (or not identified as homeless in CCMS) may be similarly stratified, though this will not be known until assessments are conducted.

Severe Risk	Top 5% of users of urgent/emergent services AND Homeless > 10 years (In CCMS)	570	3.4%
High Risk	Top 5% of users of urgent/emergent services AND Homeless ≤ 10 years (In CCMS)	754	4.4%
	Homeless > 10 years (not in top 5%) (In CCMS)	2,702	15.9%
Elevated Risk	Homeless (NOT in top 5% and homeless ≤ 10 years) (In CCMS)	5,949	35.1%
To be assessed	Homeless (NOT in CCMS or NOT identified as homeless in CCMS)	7,000	41.2
TOTAL		16,954	100%

The methodology is based upon a number of historical factors, including the span of time the individual has experienced homelessness, which might be continuous or sporadic. Presenting conditions might also elevate a client's risk stratification. Other risk factors are the individual's use of urgent/emergent services, and use of multiple healthcare systems. Urgent/emergent services are monitored by systems of care using service counts as follows:

- Medical System: Inpatient days, ED visits, Urgent Care visits, Medical Respite days, ambulance transports
- Mental Health System: Inpatient days, Psych Emergency visits, Crisis Intervention encounters, Acute Diversion days, Urgent Care visits
- Substance Abuse System: Sobering Center visits, Medical Detox days and Social Detox days

This risk stratification methodology will be studied and refined throughout the WPC Pilot, with particular attention paid to the Elevated Risk category to evaluate other stratifications based on vulnerability (e.g., youth, elderly, women) to determine whether movement into higher risk categories can be prevented.

The intensity of interventions will be based upon stratified risk: The most intensive interventions will focus on the 1,324 patients who are also very high users of urgent/emergent services.

Identification of the Target Population

Given San Francisco's significant focus on homelessness and the timing and alignment of multiple initiatives and priorities to serve this population, WPC Pilot partners agreed early on to focus on San Francisco's homeless population. To refine the focus, city agencies – SFHSH, SFDPH, the Department of Aging and Adult Services, the Human Services Agency, and the Mayor's Office – convened city partners – both Medi-Cal managed care plans, as well as community-based organizations, HealthRIGHT 360, Baker Places, and Institute on Aging. We also had separate conversations with non-

profit hospital leaders. Representatives from each of these organizations met several times in the lead up to the submission of the Round 1 WPC application and have continued to meet regularly to review data and develop data sharing processes in preparation for this application.

The group reviewed data from a number of sources, including CCMS, San Francisco's bi-annual point-in-time homeless surveys, the homeless services audits performed by the San Francisco Controller's office and the San Francisco's Budget and Legislative Analyst, and other relevant sources. The group agreed that every homeless adult will be assessed and have a health record, and that risk stratification will direct intensive resources to those with the highest need. "Severe" and "High Risk" Homeless (high users of urgent/emergent services and/or those who have experienced over ten years of homelessness) experience twice the rate of serious health disorders and three times premature mortality than the general homeless population.

SECTION 3: SERVICES, INTERVENTIONS, CARE COORDINATION, AND DATA SHARING

Section 3.1 Services, Interventions, and Care Coordination

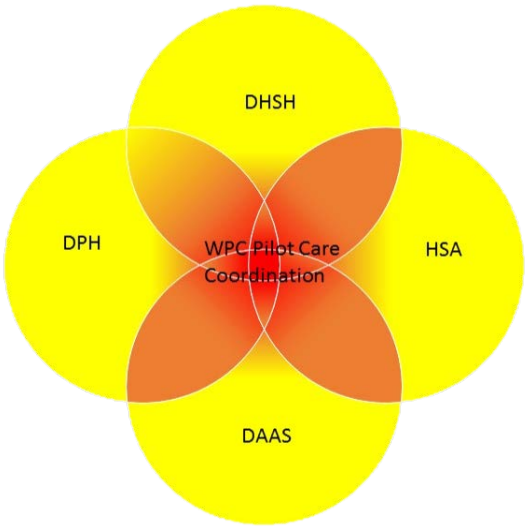
Overview

The WPC Pilot proposal incorporates lessons learned from San Francisco's Navigation Center. The first Navigation Center, opened in March 2015, provides a range of on-site services for the adult homeless population. The Center has co-located services for healthcare and entitlement benefits, connects people with social services and long-term housing, or helps reconnect them with loved ones. As of July 2016, over 80% of clients had positive exits, including: 216 reconnections with family; 152 placements in supportive housing; 16 placements into stabilization units; and four placements into residential treatment. This new Navigation Center approach to homelessness provided the lessons that are the foundation of this proposal:

- need for a universal assessment to ensure that the right clients are placed into the right services at the right time;
- need for real-time client data to make the best decisions for a highly mobile and often hard-to-reach population; and
- need for improved care coordination to enable clients to obtain the services they need precisely when they are ready.

By creating a system that invests in innovations in infrastructure and service, the WPC Pilot will improve the lives of people experiencing homelessness in San Francisco.

Figure 1: Care Coordination Model



Innovations in Infrastructure

The WPC Pilot invests in MACCS, which comprises a data-sharing platform, a multi-agency universal assessment tool, and enhanced care coordination capabilities.

Data Sharing Platform

The MACCS data and care coordination hub centralizes critical data on homeless adults accessing SFDPH's public healthcare services. It is at the core of San Francisco's WPC Pilot. Medical, behavioral, emergency, and social service data will be integrated into one interactive platform, which will be accessible to service providers (in compliance with all privacy laws) in real-time to help them make critical decisions for their patients and clients. The vision for MACCS is described in detail in Section 3.2.

Universal Assessment Tool

MACCS also incorporates the development of a standardized multi-agency assessment tool that will be used to evaluate the needs of all homeless individuals seeking services in San Francisco. Pulling from historical information known about the client and real-time interviewing, the universal assessment will measure client acuity across multiple domains (e.g., health, length of homelessness) and stratify individuals into risk categories that will guide the intensity of interventions.

Care Coordination

San Francisco has a range of existing case management programs at SFDPH, SFHSH, the Human Services Agency, the Department of Aging and Adult Services, and others to help clients navigate services. However, as in other parts of our system, they are siloed and do not communicate well or regularly. Using the power of data and standard assessment, MACCS will bolster the case management infrastructure by centralizing

tracking of care coordination activities for WPC Pilot participants and prioritizing those with the highest risk stratifications for the most intensive interventions (see Figure 1).

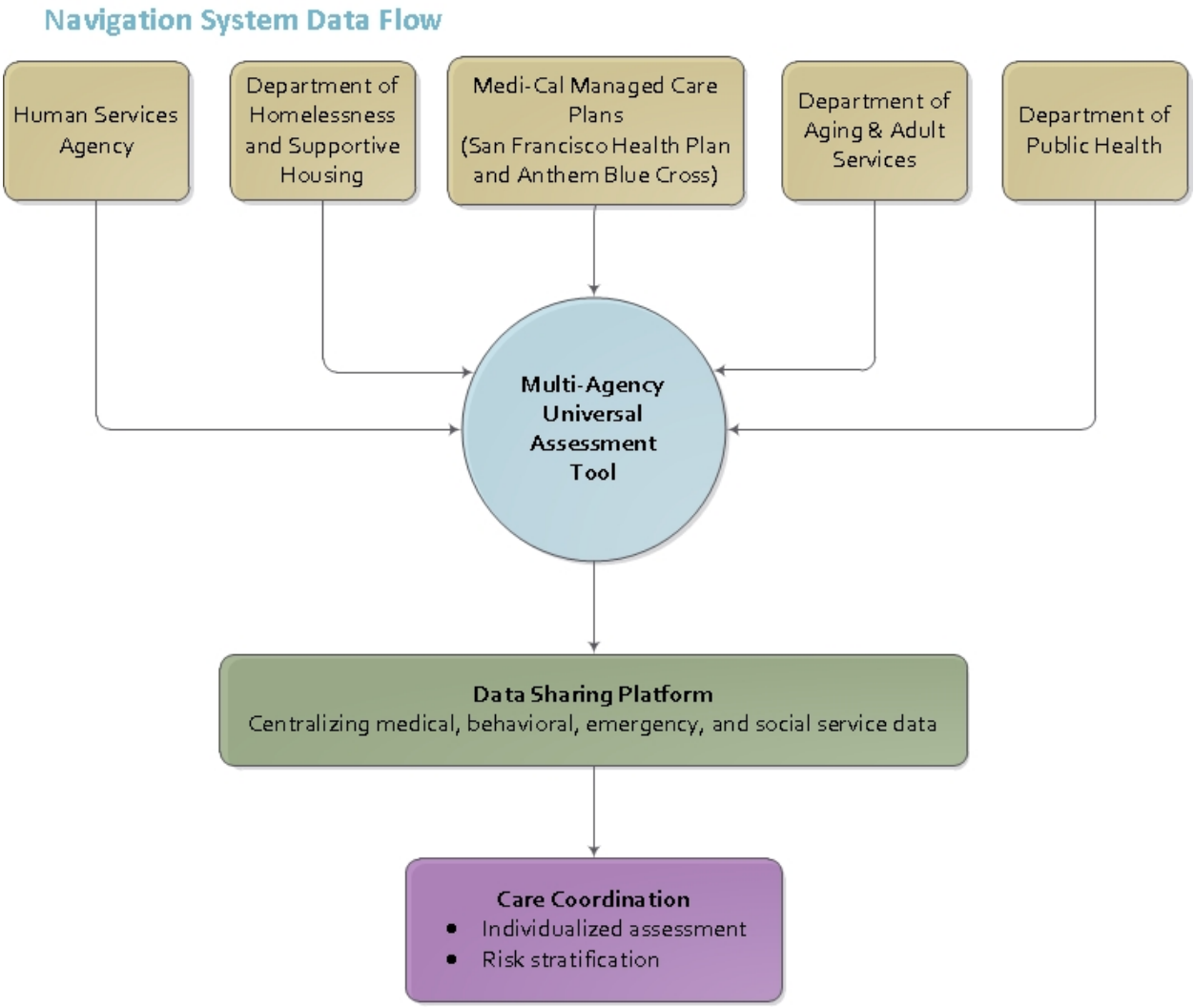
The WPC Pilot will employ centralized care coordinators reporting to the Program Director. These care coordinators will collaborate with the client's primary case managers to develop a Community Care Plan. Focusing on the highest risk patients, the WPC Care Coordination Team will additionally:

- Remove barriers to facilitate timely connections to needed services, which may include medical care, conservatorship, intensive case management, mental health and substance abuse residential treatment;
- Ensure other providers are alerted to the client's elevated status;
- Dispatch engagement workers to locate individuals in the streets or pickup wherever they present; and
- Provide transitional or bridge case management services and continuously monitor the client until they are fully engaged in care.

As the elements of MACCS advance in their development, the WPC care team will have increased access to accurate and comprehensive information to connect clients with appropriate services in a timely manner.

Foundation for a Citywide Navigation System

The data-sharing platform, the universal assessment tool, and the risk-stratified care coordination model are key elements not only of MACCS, but also of SFHSH's broader Navigation System. While MACCS focuses on homeless San Franciscans with high healthcare needs, the Navigation System focuses on all homeless San Franciscans. Because a significant proportion of the homeless population has high healthcare needs, investments in MACCS will become the foundation for the broader Navigation System infrastructure. With the new SF HSH launching today, MACCS helps set the stage for true interdepartmental collaboration to improve health and housing outcomes for homeless San Franciscans. Figure 2 depicts the data infrastructure for the Navigation System.



Innovations in Service

Existing Services

The full continuum of existing health, social, and housing services available to homeless San Franciscans through SF HSH, SFDPH, and the Human Services Agency will be leveraged to support individuals enrolled in the WPC Pilot. Broadly, these services include:

- Screening for and enrollment into Medi-Cal and other public benefits;
- Comprehensive medical, behavioral health, and social services;
- SF HOT (Homeless Outreach Team), which works in small teams to engage homeless individuals on the street to provide case management, medical care, and linkage to housing and services;
- Rapid Targeted Coordination and Navigation Team; currently consists of one staff;

- Homeless services and housing supports; and
- Case management

Services to Fill Identified Gaps

In addition to these established services, the WPC Pilot proposes supplementary services to fill identified gaps in care. Those additional services are detailed below.

Navigation Centers

A Navigation Center is a specialized, low-threshold shelter allowing couples, pets, and belongings. The first Navigation Center created a model for engaging homeless individuals with significant barriers to utilizing the traditional shelter system. It brought together services and staff from multiple City agencies and non-profit partners to streamline the processes by which homeless individuals connect to benefits and exit into reserved long-term shelter or stable housing. Clients are referred by Rapid Targeted Coordination and Navigation Team and Homeless Outreach Team. Beds are in high demand, and new navigation center openings will be very welcome in the community.

Expanding Medical Respite

The WPC Pilot proposes to expand San Francisco's existing Medical Respite shelter to provide medical and psychosocial care for those whose needs cannot be safely met in a regular shelter setting. A recent assessment of shelter residents found that over 53% had a psychological condition, nearly 50% had a medical condition that contributes to early mortality, and almost 60% have used urgent/emergent services. The Medical Respite expansion would be an alternative to hospital emergency departments as well as a destination for hospital discharges, providing a period of recovery and stability for individuals who would otherwise be on the street.

Building Capacity to Expand Detoxification Services

The rate of alcohol and drug dependency among the Severe Risk WPC population is more than 90%. SFDPH currently supports residential detoxification programs at HealthRIGHT 360 and Baker Places and nearly half of the top 5% users of urgent/emergent services access them. While residential detox services will become reimbursable under the Drug Medi-Cal Organized Delivery System, significant investments are required to prepare these programs to meet staffing, documentation, and audit requirements. This WPC Pilot proposes to build the infrastructure needed to sustain these programs under Drug Medi-Cal.

Extension of Residential Substance Use Disorder Treatment

Drug Medi-Cal provides for residential treatment in 30-day increments up to a total of 90 days. However, 90 days is not always sufficient for high utilizers with long-term substance use disorders, and many dually- or triply-diagnosed clients in the WPC Pilot may require 12 weeks or more just to stabilize from co-occurring medical or mental

health conditions. An extended stay, authorized individually on an as-needed basis, would address substance use disorder treatment in meaningful way and ensure that a client's mental and physical needs are addressed to maximize success upon discharge.

Reducing Institutional Care for Homeless Seniors

To address the aging homeless population, the Institute on Aging will provide intensive transitional care management services to enable discharge or prevent institutional care for homeless seniors who would otherwise be "housed" in long-term care facilities due to their complex medical conditions. This program leverages the existing infrastructure and resources of San Francisco's Community Living Fund, which couples care management with the purchase of needed goods and services.

New Services Added in Round Two

San Francisco proposes to add services beginning July 1, 2017 (second part of PY2) through the end of 2020 (PY5) to better assist the homeless WPC clients who are harder to reach and need other types of assistance to access care. To bring additional homeless clients into care coordination, and into stable places where they can receive services and improve health outcomes, the City proposes to add four additional interventions to its WPC programming. These interventions will greatly increase the reach of WPC, and will ensure that all WPC clients get prioritized for housing and other long-term assistance.

WPC Unique Client Tally	PY2	PY3	PY4	PY5	Total	Unduplicated
Resource Center	18018	36135	36135	36135	126423	5148
Coordinated Entry	1980	3960	3960	3960	13860	13860
Rapid Targeted Coordination and Navigation	8363	8363	8363	8363	33452	1440
Enhanced Housing Transition	800	700	600	600	2700	1620
Housing & Tenancy Stabilization	600	1100	1100	1100	3900	1950

The new services will assist clients as follows:

While each service is unique, we imagine many clients will use more than one of them.

The Resource Center will primarily serve people who are not in Navigation Centers, so may not overlap significantly with originally proposed services. It will overlap, though, with RTCN services, as RTCN teams will urge clients to access the Resource Center.

We expect all clients we serve in our original and our expanded application (those new to services after July 1, 2017) will be assessed and prioritized for Coordinated Entry, if

they consent.13,860 new clients are anticipated through WPC as a subset of the 16,954 unduplicated members discussed in section 2.3 above.

Enhanced Housing Transition and Housing & Tenancy Stabilization will not overlap with the other services in a foreseeable manner, except at the initial point of enrollment, and before housing placement, at which point a client could be staying at a Navigation Center.

Resource Center

San Francisco continues to have insufficient shelter and housing resources to meet the needs of its unsheltered population. HSH proposes new strategies to provide respite and service connection to people living on the street. In 2018, the Department has plans to open a 24-hour/7 days-a-week resource center where people experiencing homelessness can access restroom facilities, take showers, receive services, and enroll in county benefit programs. HSH proposes using the resource center to provide care coordination for the City's chronic homeless population leveraging funding through the Whole Person Care pilot. Within the center, clients will be assisted by staff who conduct triage and assessment work to enter them into Coordinated Entry, and will receive care coordination assistance in making connections to medical and behavioral health care.

On any given day, San Francisco has more than 6,000 homeless residents (based on the homeless point in time count data). Currently, there are over 1,000 shelter and navigation center beds each night, but that leaves several thousand with no place to go. While HSH brings on additional shelters, navigation centers, and supportive housing units, a Resource Center will be established to provide brief assistance to people living on the streets or in emergency shelters. The Resource Center will be open 24 hours, but will not have or require reservations like Navigation Centers and emergency shelters do. There will be places to rest, but the resource center does not function as a sleeping place.

In addition to seating areas, the Resource Center will have on-site social workers to assist people who need immediate social services. While some people living on the streets are connected to case management, those services have more limited hours and their staff cannot always locate clients as encampments and solo campers move frequently.

The Resource Center will open in PY3, and remain open through PY5. This is proposed as a Fee for Service, and will track the number of unduplicated beneficiaries accessing the center on a daily basis. HSH is projecting encounters assuming that 150 clients per day will access the center, and that 66% (99) will be WPC eligible.

Coordinated Entry

HSH will staff and provide resources for coordinated access to all shelter and housing programs for WPC beneficiaries. Outreach and assessment staff will conduct initial intake and triage assessments, and will connect beneficiaries with housing navigators or other service providers to complete full assessments for housing prioritization and

placement. All coordinated entry assessments will be entered directly into the ONE System for immediate entry into housing prioritization status. Clients with a high priority score are given expedited access to Navigation Centers and housing navigation assistance. The coordinated entry specialists will continue to provide care coordination, housing navigation, and referrals to needed assistance throughout the time the client is experiencing homelessness, for all beneficiaries living on the street and in encampments. This expansion will add coordinated entry specialist positions to travel with the HOT and RTCN staff, adding all WPC clients into the CE system as soon as they are identified.

Coordinated Entry Roving Team services seek out clients who are in the top tier of prioritized clients eligible for supportive housing.

Rapid Targeted Coordination and Navigation (RTCN) Team Services

Like many cities, San Francisco has seen a huge increase in numbers of people living in tents set up under freeways and on sidewalks. Current numbers show more than 4,000 complaints received on a monthly basis through 311. HSH currently has an RTCN with one staff. Through WPC, HSH proposes to expand RTCN with the add care coordination staff. This added staff will allow RTCN to address two encampments simultaneously, more than doubling the RTCN capacity.

As of April 2017, there are at least ten known encampments with eight or more structures, and one encampment with more than 100 residents. RTCN response protocols for engaging residents are summarized here:

Phase One begins with outreach when an encampment is calendared as next up for resolution. Once the encampment is placed on the Encampment Master Log, engagement begins. These are clients that typically would not be found elsewhere such as in shelters.

Phase Two consists of concentrated intense engagement for 21-42 days with a set end date for all encampment clients and continued characterization of their needs. Provision of treatment also begins during this phase with RTCN intake and release of information completion, connection to DPH health providers, and Navigation Center/emergency shelter move-ins. All encampment clients are offered shelter or navigation center services with maintenance of engagement and care coordination. Staff coordinates extensively with health, police, and public works to maintain safety of the clients.

During resolution, RTCN collaborates closely with other city departments (as necessary and appropriate) to close the campsite and assist remaining clients to places of safety and respite.

With additional staffing, RTCN will have capacity for two teams of three, addressing two encampments simultaneously, and engaging twice as many people with care coordination assistance. HSH expects to contact more than 120 people per month, at least 66% (80) of whom will be WPC eligible, through the expanded RTCN.

Eligibility for RTCN WPC assistance will be based on RTCN intake that includes screening questions for Medi-Cal eligibility and needed intake questions for WPC. Full assessments including housing assessment are completed with coordination with primary care, connections to on-site health fairs and nursing, referral for treatment, behavioral health triage, and connections to ongoing services. A service plan is developed for all encampment clients with crisis intervention and linkage to resources. RTCN services will be provided on a per-encounter basis, but Care Coordinators will work with clients until they are placed in shelter or housing, working with them on treatment options, where appropriate, on gathering needed documents, and on identifying a path to housing and safety.

Enhanced Housing Transition Services

Research and our experience clearly show that homeless individuals, and especially people experiencing long-term homelessness, need significant support in making the transition into housing. This includes benefits eligibility support, searching for housing placement, landlord engagement, and coordination of health and other services.

Eligibility will be based on prioritization status and membership in the target population. Prioritization is based on custom tool factoring length of homelessness, chronicity, and vulnerability factors including mental illness and physical disabilities. When someone is in the top tier, or Priority 1, they are connected with Enhanced Housing Transition services for navigation, document preparation, housing locator services, and services that support a member's ability to prepare for and transition to housing. Specific transition services will include:

• Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.

• Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
• Assisting with the housing application process. Assisting with the housing search process.

• Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.

• Ensuring that the living environment is safe and ready for move-in.

• Assisting in arranging for and supporting the details of the move.

• Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

Program Start: Clients will be enrolled in enhanced Housing Transition services when they have been identified as high-priority for permanent supportive housing by Coordinated Entry, HOT, or RTCN staff. HSA eligibility workers will ensure enrollment in cash and nutrition benefits, and housing navigators will assist with housing unit identification, making and keeping housing appointments, getting documents such as ID and income verification, and securing other needed items for move-in. Housing Transition Services will collaborate closely with housing providers' on-site teams to assist with housing stabilization and retention.

Program End: Enhanced Housing Transition services will discontinue when a client has successfully moved into housing and has been added to the on-site or mobile team provider's caseload for tenancy stabilization. Services may also be discontinued if a client has left the program voluntarily, or if a client cannot be contacted. If a prioritized client loses contact, then returns, she or he will be added back to the caseload. Membership will be verified on a monthly basis. Services will typically last between 30 and 90 days.

Numbers: HSH projects assisting approximately 250 people per month with housing navigation and benefits eligibility, and that 80% of those will be 200 WPC members. For 200 WPC members per month, this will require a staffing level of 10.5 FTE.

Housing and Tenancy Stabilization Services

San Francisco will bolster and standardize its care coordination resources in supportive housing through Tenancy Stabilization services. The county is poised to bring all funded to assist homeless tenants into its Coordinated Entry system, thereby adding significant referral capacity. Adding this volume of new homeless referrals into properties with little existing services staff will require supplemental care coordination and clinical supervision.

Specific Tenancy services will include services that support the member in being a successful tenant and thus able to sustain tenancy.

• Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.

• Education and training on the role, rights and responsibilities of the tenant and landlord.

• Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

• Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.

• Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized.

• Assistance with the housing recertification process.

• Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

• Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

Eligibility: Homeless beneficiaries placed into permanent housing will be eligible for Housing and Tenancy Stabilization services.

Program Start Housing and Tenancy Stabilization services will be provided for people moving in to permanent housing, referred through Coordinated Entry. Beneficiaries may be enrolled as soon as a unit is identified and/or a lease is signed.

After move-in, care coordination (with supervision for services delivery) will continue throughout tenant stabilization. Services will continue through housing stabilization. Services will end if the tenant no longer needs assistance within the housing site, or when she or he moves away from the housing site and no longer needs assistance. Tenancy Stabilization will not overlap with the other services in a foreseeable manner, except at the initial point of enrollment, and before housing placement, at which point a client could be staying at a Navigation Center.

Expected Length of Stay: Housing Stabilization service providers will work with clients for an average of 12-24 months after placement.

Program End: Tenants may choose to discontinue services if there are adequate on-site services to provide ongoing support needed, or if the tenant no longer needs the higher level of support offered under WPC.

Numbers: Once in housing, HSH will work with its partners to provide assistance at a 1/25 staff to client ratio. For 700 WPC members per month, this will require 20 new FTE, combined with on-site assistance where available. Tenancy Stabilization services will be provided for an average of 12-24 months after placement. As people transition off assistance, new tenants will be added.

Section 3.2 Data Sharing

Coordinated care among San Francisco's numerous homeless services providers is hindered by a decentralized data infrastructure. Regulatory, privacy, and service mandates require each agency to maintain program-specific documentation systems. Additionally, none of the current applications has the interoperability to exchange information to provide a 360-degree view of the client either in real-time or retrospectively, nor the functionalities to facilitate seamless communication and care coordination across agencies.

Sustainable Infrastructure for Information Exchange

MACCS is the core of the WPC Pilot and one cornerstone of the technology solution for SFHSH's broader Navigation System that will enable San Francisco to serve its homeless clients holistically. Among the goals of the new SFHSH is to create an information technology platform that integrates medical, behavioral, and social data with housing information. This data would be accessible to the greatest extent allowable under privacy laws to providers of health and homeless services, anytime, anywhere, and on any device.

The MACCS infrastructure will explore the opportunity to harness the power and security of the cloud, as well as mobile technologies to deliver a comprehensive, real-time view of each client's health and social data to develop an interagency shared community care plan and alert members of the client's care team of key events. The WPC Pilot will explore partnering with a technology innovator, such as Salesforce and its Health Cloud, a client relationship platform that can aggregate multiple datasets and streamline care coordination for clients. Together, the WPC Pilot partners will:

- Identify the initial use case;
- Define input and output data for care planning and coordination;
- Determine source system configuration and architectural design;
- Determine directionality of the data between systems;
- Determine the timeliness of the data; and
- Create a data model and information governance structure.

Integrating Information from Multiple Sources

The WPC Pilot will integrate multiple information systems and data sources through MACCS in order to promote collaborative planning and care coordination for the WPC target population:

- Coordinated Care Management System (CCMS) – Centralized repository of data from 15 data sets providing a "whole person" profile comprising 20 years of essential medical mental, and substance abuse health histories and social information on our vulnerable populations served by SFDPH;
- Homeless Management Information System (HMIS) – to be implemented by October 2017, the system of record providing coordinated entry to all SFHSH homeless services;

- Enterprise Electronic Health Record (EHR) – to be implemented by late 2018, a unified electronic health record integrating data on medical, behavioral, substance use, and correctional health services provided by SFDPH;
- Multiple Human Service Agency (HSA) Information Systems – various data systems that track eligibility for public assistance and In-Home Supportive Services; and
- Emergency Department Information Exchange (EDIE) – a web-based communication technology that enables intra- and inter-emergency department communication and is used for the Health Homes program by San Francisco's Medi-Cal managed care plans, San Francisco Health Plan and Anthem Blue Cross.

Strong Data and Information Sharing Governance

Significant data security, privacy, compliance and ownership concerns must be addressed to ensure both client rights and organizational liabilities are fully protected. An early critical success activity will be to convene each partner's respective information technology, legal and compliance teams and to tightly project manage that group to assure the WPC Steering Committee can reach agreement and execute contracts or memoranda of understanding (MOUs) on data sharing and governance.

Managing Potential Implementation Challenges

Forces that may negatively impact project scope, schedule, cost, and outcome include: legal and regulatory restrictions; data sharing constraints; technical delays; low user adoption; poor accountability to outcomes; and competing organizational priorities. To mitigate these potential barriers, the Operation's Committee's data sharing subcommittee will be integrated into the WPC Pilot governance structure. This monthly forum will involve high-level leaders from each partner agency and will use an executive visual dashboard to summarize and present status updates to build project-wide accountability.

Implementation Timeline

Pilot Year	Activities
2016	• Application preparation and revision • Establish Steering Committee
2017	• Establish MACCS Program Management Office • Secure contract for HMIS vendor solution • Implement EDIE • Begin analysis of available datasets, user needs, and measures of success • Develop workplan, governance structures and working committees
2018	• Install and implement HMIS • Secure contracts for relevant technology solutions

Pilot Year	Activities
	• Sign MOUs for data sharing and care coordination accountability
2019	• Install and implement SFDPH enterprise EHR • Complete system configuration and data integration for CCMS, HMIS, HSA systems, and EDIE • Design, build and test workflow processes, and decision support
2020	• Complete system configuration and data integration of EHR • Validate and refine care team workflow processes and decision support algorithm • Implement population health analytics to target client segments for specific interventions • Initiate program evaluation and impact assessment
2021	• Complete program evaluation

SECTION 4: PERFORMANCE MEASURES, DATA COLLECTION, QUALITY IMPROVEMENT AND ONGOING MONITORING

4.1 Performance Measures

Members of the WPC Pilot target population will experience two interventions: 1) a connected electronic infrastructure for care coordination (the Multi-Agency Care Coordination System – MACCS), and 2) augmentation of certain services with a move toward value-based care models. The result is a homeless single adult living on the streets or in the shelters of SF can experience treatment access opportunities coming faster and closing gaps that previously required the individual to travel around the city for services and tell their personal history many times. A Medi-Cal eligible beneficiary with worsening disease conditions and escalating treatment costs is most likely to notice the difference.

The WPC Pilot partners will be reimbursed for these achievements and activities according to performance measures that emphasize planning and implementation in pilot years 1 and 2, then completion and refinement in years 3, 4, and 5. The WPC Pilot Attachment MM is the guiding document throughout all performance measures.

1) Universal Metrics

Universal health outcome measures #1-5 apply to the impact being made by service delivery interventions. They are the shared responsibility of partners having contact with homeless individuals. Payment for reporting refers to tracking and reporting the health outcome measures in a standardized timely manner and is requested for all five. Payment for improved outcomes is attached to the first four. Partners will receive payment if standardized reporting shows measurable improvement over time. The relative amounts of compensation will shift over the course of the pilot to emphasize outcome improvement more than standardized reporting.

Universal metric #6 requires an administrative organizational structure that is the responsibility of SFDPH as the lead partner. This metric will be reported, but no payment is attached. Each of the WPC partners will contribute to developing contracts, MOUs, scope of practice, and policy and procedure documents that will govern the WPC Pilot. Each partner will have contracts or MOU documents specifying participation.

Universal metric #7 requires the planning and implementation of a shared data structure. This metric will be reported, but no payment is attached. All partners will contribute via regular meetings to the planning and decisions regarding infrastructure technology.

2) Variant Metrics

Variant metrics 1-4 emphasize that this WPC Pilot wants to create a health and social record for every homeless individual and connect them to the resources they need to maintain their health and well-being and the community's wellness as well.

Variant 5 measures the commitment to ensuring individuals have the support services they need to stay in their chosen housing. No one benefits if homeless individuals cycle in and out of housing.

Outcome metric 1 protects everyone from communicable diseases and is essential pre-requisite for transition into residential treatment.

Outcome metric 2 measures the success of our ability to transition a high-need individual from a permanent housing referral into placement.

Outcome metric 3 measures the success of our ability to identify and serve in our high-need permanent supportive residents who benefit from enhanced care coordination.

Outcome metric 4 measures the success of our ability to identify and assess homeless individuals for coordinated entry.

Outcome metric 5 – measures efficiency in offering housing or shelter during Encampment to Placement. CCSF will seek to reduce by 5% the length of time it takes from initiating an encampment response (first encounter/touch) until the WPC clients are placed in shelter or housing.

Outcome metric 6 measures the number of participants referred for housing services that receive services.

Reporting and evaluation will follow the WPC Pilot Attachment GG throughout the pilot period. Data transmission to SFDPH will be electronic as the preferred method. Initially health and social input will arrive through CCMS, and shelter and housing placement will transmit via HSA. The Navigation Centers will use alternative reporting initially. As the pilot progresses and infrastructure is completed, all data will be retrieved from the new system.

The addition of new services to the WPC pilot will reinforce the metrics that are already in place and strengthen our ability to meet existing targets.

4.1.a Universal Metrics

☑ Health Outcomes Measures

☑ Administrative Measures

Universal metric	**PY1**	**PY2**	**PY3**	**PY4**	**PY5**	**Participating entities**
U1. Emergency Department Utilization HEDIS	Baseline for report period: # ED visits by	Maintain baseline	Reduce by 5% compare	Reduce by 10% compare	Reduce by 15% compare	DPH

Universal metric	PY1	PY2	PY3	PY4	PY5	Participating entities
	WPC enrollees/ count of WPC enrollees using ED		d to baseline	d to baseline	d to baseline	
U2. Inpatient Hospital Utilization HEDIS	Baseline for report period: # of inpatient stays and days by WPC enrollees / # of WPC enrollees using Inpatient.	Maintain baseline	Reduce by 5% compared to baseline	Reduce by 10% compared to baseline	Reduce by 15% compared to baseline	DPH
U3. Follow up after hospitalization for Mental Illness HEDIS	Baseline for report period: # of WPC enrollees in psych inpatient who receive follow-up / # of WPC enrollees in psych Inpatient.	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline	DPH Behavioral Health Services
U4. Initiation and engagement in alcohol and other drug dependence treatment HEDIS	Baseline for report period: # of WPC enrollees using residential AOD detoxification and linked to follow-up trmt / # of WPC enrollees using detox	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline	DPH Behavioral Health Services Baker Places HR360
U5. Proportion of beneficiaries with care plan accessible by entire team w/in 30 days of enrollment and	Baseline for report period: # of WPC enrollees in psych ED and Inpatient receiving MH	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline	DPH HSH HSA DAAS/IOA Baker Places HR360

Universal metric	PY1	PY2	PY3	PY4	PY5	Participating entities
anniversary in program	follow-up treatment who have care plans / # WPC enrollees in psych ED and Inpt.					
U6. Care coordination, case management, and referral infrastructure	Baseline: examine needs for written documentation	Develop contracts, MOUs, scope of resp, care coordination	Update	Update	Update	DPH HSH HSA DAAS Baker Places HR360
U7. Data and information sharing infrastructure as measured by documentation of policies and procedures for all entities that provide care coordination, case management monitoring, strategic improvements.	Baseline: examine needs for written documentation	Develop contracts, MOUs, scope of responsibilities, care coordination	Update	Update	Update	DPH HSH HSA DAAS/IOA Baker Places HR360 SF Health Plan Anthem BC

4.1. b Variant Metrics

Variant Metric	Numerator	Denominator	PY1	PY2	PY3	PY4	PY5
1. Completion of Universal	Total # of WPC participant	Total number of WPC	Baseline: counts completio	Maintain baseline	Increase by 5% compare	Increase by 10% compare	Increase by 15% compare

Variant Metric	Numerator	Denominator	PY1	PY2	PY3	PY4	PY5
Assessment Tool with homeless individuals	s during the reporting period with assmts (medical, psych, substance use, housing, benefits)	participants during the reporting period	n of assessments		d to baseline	d to baseline	d to baseline
2. Health Outcomes: 30 day All Cause Readmissions	Count of 30-day readmissions	Count of index hospital stay (HIS)	Baseline: count of hospital readmission w/in 30 days previous discharge	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline
3. Health Outcomes: Decrease Jail Recidivism	Total number of incarcerations of WPC participants during the reporting period	Total number of WPC participants during the reporting period	Establish Baseline:	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline
4. Health Outcomes: Suicide Risk Assessment Required for Pilots w/ SMI Target Population	Patients who had suicide risk assessment completed at each visit	All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder	Baseline: available in PES and Psych Inpatient	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline

Variant Metric	Numerator	Denominator	PY1	PY2	PY3	PY4	PY5
5. Housing: Permanent Housing	Number of participants in housing over 6 months	Number of participants in housing for at least 6 months	Establish Baseline:	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline

Outcome Metric	Numerator	Denominator	PY1	PY2	PY3	PY4	PY5
1. Obtain TB clearance in preparation for next treatment placement	Total number of WPC participants during the reporting period w TB clearance	Total number of WPC participants during the reporting period	Baseline: available in CCMS	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline
2. Housing: Supportive Housing Services	Number of participants referred for supportive housing who receive supportive housing services.	Number of participants referred for housing services	N/A	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline
3. Housing Enhanced Care	Number of participants who receive supportive housing assessed from enhanced care	Number of participants who receive permanent supportive housing	N/A	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline

Outcome Metric	Numerator	Denominator	PY1	PY2	PY3	PY4	PY5
	coordination						
4. Coordinated Entry Assessments	Number of homeless participants assessed using universal assessment tool	Number of homeless participants	N/A	Maintain baseline	Increase by 5% compared to baseline	Increase by 10% compared to baseline	Increase by 15% compared to baseline
5. Encampment to Placement.	Sum of the number of days from each enrollee from the day of the first encounter to the day of being placed in shelter/house.	Total number of enrollees being placed from encampment to shelter during the reporting period.	N/A	Maintain baseline	Decrease by 5% compared to baseline	Decrease by 10% compared to baseline	Decrease by 15% compared to baseline

Section 4.2 Data Analysis, Reporting and Quality Improvement

Data Analysis, reporting and quality improvement will be conducted in the SFDPH performance framework consisting of three pillars: mindset, skillset, and toolset. The Mindset pillar creates a learning organization, whereby problem solving and the use of data for improvement is cultivated. The second pillar, Skillset, focuses on the development of internal capacity and staff aptitude to improve on inefficiencies and challenges in the workplace. Lastly, the Toolset pillar recognizes that in order to improve, we need to leverage technology, data systems, registries, and analytics, together with the first two pillars to be successful.

Data Analysis/Reporting (toolset)

Essential to measuring the impact of the WPC Pilot, MACCS will support data collection, risk stratification, analysis, and reporting. An information technology (IT) subcommittee of the Operations Committee will be responsible for mapping the elements of each measure to MACCS. Subcommittee members will create a standardized data dictionary and nomenclature for the documentation of key performance and process measures. This process will create a uniform language from which to report and discuss data. SFDPH has already created a data validation process

and procedure to ensure the accuracy of the data capture and will incorporate these protocols into the development of the MACCS. Automated monitoring systems will be created to alert IT staff and assess completeness of data transfer between systems.

Once the data warehouse is created, an electronic performance dashboard, consisting of key driver and process metrics, will be produced; it will have the ability to drill down to the agency, and navigation center level. Regular data flow will allow for the availability of timely, actionable dashboards. Patient level registry lists will identify from the universal assessment tool, gaps in care. Data can be analyzed to assess a variety of concerns, including identifying patients at highest risk, those who have fallen out of care, and those who are not engaging.

Performance measures will be posted electronically on a shared platform or pushed out for front line staff, workgroups, and executive sponsors to discuss.

Taking a population health approach, patient lists will also be generated to identify patients (still assuring confidentiality) who are missing key services from the universal assessment tool and community treatment plan. Local agencies and navigation centers can proactively engage patients to link them to much needed services.

While each participating entity in the WPC Pilot will be responsible for data submission, SFDPH will take ultimate responsibility for reporting of data on the metrics.

Coaching and Review Process (Mindset)

The Operations and Steering Committees will review the dashboard and performance measures regularly to ensure that agencies and navigation centers are staying on track. Using a standardized report out format, executive sponsors and champions will be asked clarifying questions and coached towards improvement. Real case scenarios where system or bureaucratic issues impede health and housing goals will be presented and discussed. General themes, trends and case reviews from among the different agencies, along with common barriers, will be escalated to the Steering Committee for resolution.

The participating agencies and their teams are expected to also review their metrics regularly, using the data to inform new interventions, and to decide on whether to adopt, adapt or abandon current interventions. Failures will prompt learnings and those teams, which are not able to achieve milestones, will be directed to devise alternative performance improvement plans (PIP). Additionally targeted coaching in quality improvement principles and tools (e.g., process mapping, root cause analysis, and rapid cycling PDSA) will address performance issues.

In an effort to create a culture of quality, WPC pilot teams will incorporate performance improvement discussions into regularly occurring staff meetings and huddles, creating a performance improvement mindset in all staff.

Quality Improvement (PDSA) Process (Skillset)

The foundation for this three-pillared framework is the Model for Improvement and the PDSA. Consistent with this model, is:

- The setting of an AIM statement: what are we trying to accomplish?
- The development of performance measures: how do we know that a change is an improvement?
- The execution of countermeasures: what changes can we make that will result in an improvement

SFDPH has a robust, 11-month Quality Improvement Learning Academy that trains teams of staff in problem solving skills, the use of data for improvement, rapid PDSA cycling, and change management.

WPC pilot teams will be taught the fundamental quality improvement principles and how to apply them to the proposed interventions. WPC Pilot workgroups and champions will meet regularly to create local performance improvement goals, develop project milestones and project plans (PLAN). Interventions will be scoped to allow for small steps of change, and rapid cycling (DO). Monthly review of the project plans and dashboard performance measures between executive sponsors and champions will ensure that proposed interventions are analyzed (STUDY), on track, and that barriers encountered are dealt with in a timely manner (ADJUST). Lastly, interventions and countermeasures will be evaluated based on a number of factors, including, sustainability, value added outcomes, resources required, simplicity of design, and return on investment. These factors will determine whether the solutions need additional refinement, are ready for spread, or should be terminated.

PSDA FUND

This WPC Pilot incorporates the Plan-Do-Study-Act (PDSA) process throughout the service interventions as well as the care coordination models proposed here. The oversight and governance model we have put in place for this pilot as well as the rich data infrastructure that we are developing provide the necessary elements for the PDSA improvement process. We are also proposing the establishment of a PDSA Fund that to allow us to test responses to identified needs. This fund, which would be administered by the San Francisco Public Health Foundation, would be flexible and quickly accessible to enable the WPC Pilot to conduct small-scale tests of change. Those with promise could be brought to scale, and, as needed, addressed through the program modification process. Examples of the types of expenditures that might be covered by the PDSA Fund could include pay for performance program, implementation of high value activities such as home visits, transportation, Daytime activities, and patient incentives.

Section 4.3 Participant Entity Monitoring

Through meetings and case conferencing, SFDPH plans to closely monitor the WPC Pilot services provided (both in terms of quantitative data collection/analysis/reporting and more informal feedback provided by partners and clients). The program director in

conjunction with WPC Administrative Staff and advisory committees will be responsible for developing the Quality Plan. They will manage the WPC Pilot quality and improvement activities. These activities include coordinating transfers when needed, troubleshooting care coordination challenges, audits, monitoring data quality, client flow, and client experience. The director and the various subcommittees will regularly monitor the data collected and submitted by participating entities toward the various metrics. They will troubleshoot problems, engage in PDSA cycle to address these problems, and provide on-going trainings. A health care analyst is budgeted whose responsibility includes monitoring, training, and evaluation/audits. The MOU will include standardized policies and procedures (developed and approved by the Steering and Operations Committees) for clinical practice and services, care coordination, contract terms, and obligations. The terms will define deliverables, service delivery, submission of reports, program targets, data quality and timeliness standards, conflict resolution processes, technical assistance, and termination if the terms are not met. If problems of non-performance by any partners arise, efforts will be made to develop corrective action plans to assist the organization in recalibrating its course. If the problem seems insurmountable, SFDPH will consult with DHCS.

SECTION 5: FINANCING

5.1 Financing Structure

Intake and Oversight of Funds. SFDPH will provide financial management and oversight for the WPC program. Financial reporting and decision-making will be incorporated into the proposed governance structure for the WPC pilot described in the Communications Section above. DPH will receive and distribute the funding to partner agencies. Funds will be managed under DPH and the City and County of San Francisco's accounting practices, policies and regulations. Oversight and tracking of federal funds is extensive and includes the DPH Chief Financial Officer, Health Commission, City Controller's Office, Mayor's Budget Office and Board of Supervisors. DPH has existing contractual agreements, MOUs, and other formal financial relationships with each of the partner entities that will be leveraged and modified to administer, distribute, and track pilot funding. These agreements will be used to formalize payment processes and to ensure funds are sufficient to provide reimbursement for provided services by setting clear payment maximums and establishing the conditions under which payments will be distributed.

Infrastructure Payment Distribution: The proposal includes payments to the Department of Public Health for staffing to oversee the program and develop and administer governance structure. In addition, funding is requested for creation of delivery infrastructure for the Navigation System in the newly created Department of Homelessness and Supportive Housing. The application also includes a substantial information technology program, administered by DPH, to create IT infrastructure linking data between currently detached systems and enable shared data access and coordination across multiple agencies.

Service and Intervention Payment Distribution:

Department of Homelessness and Supportive Housing (HSH). Operationalizing Navigation Centers is a critical component of the City's strategy to improve outcomes for the target population. The City has a goal of having six navigation centers open within the next two years. Because of the critical role of these centers, the proposal includes one-time incentive payments to HSH upon the opening of each center. Once the centers are open and operating, the pilot includes per-member-per-month (PMPM) funding for homeless Medi-Cal beneficiaries to cover the cost of operation of the navigation centers, delivered by DPH to HSH. The PMPM payment allows flexibility and creates an incentive to manage costs creatively.

Similarly, as part of on-going innovations to access, support, and stabilize homeless individuals, HSH projects opening a resource center in 2018. In order to incentivize the timely opening of the center, the proposal includes one-time incentive payment to HSH and FFS for annual operations

Department of Public Health (DPH). In addition to DPH's role in project oversight (in close collaboration with HSH), the pilot proposes a per-member-per month (PMPM) payment for enhanced care coordination services that are critical to keeping clients engaged in services and preventing avoidable hospital readmissions for high-utilizers. The PMPM payment structure will allow for flexibility and adaptability of these services over time.

Human Services Agency (HSA) and Department of Aging and Adult Services (DAAS). HSA and DAAS will provide care coordination services for subsets of the target population. Payments to these agencies are proposed to be made on a fee-for-service basis to leverage existing financial structures. DAAS will also subcontract with the Institute on Aging for care coordination services, through the enhanced care coordination PMPM. These agencies will be eligible to receive incentive payments based on outcome measurements.

Baker Places and HealthRight360. The two community-based, not for profit behavioral health providers will receive fee-for-service payments for residential substance use services, with added incentive payments based on outcomes. These outcome-based payments will also be used as a pilot to explore moving behavioral health services toward value-based payments.

San Francisco Health Plan (SFHP) and Anthem Blue Cross (ABC). The County's two Medi-Cal health plans will receive infrastructure funds needed to produce and manage utilization data among Medi-Cal beneficiaries needed to establish baselines and measure outcomes under the pilot. The plans will also assist in integrating EDI system data into the MACCS platform.

Payments Based on Incentives, Outcomes, and Reporting. An overarching goal of the pilot is to establish permanent operational and management practices across agencies that are consistent with value based payments. It is expected that every participating partner will have the opportunity to earn payments for their roles in

achieving outcome targets. During the first year of the pilot, the partnering entities will engage in a planning process to define how outcome-based payments for successful performance of the pilot will be distributed among agencies, and formalize the arrangements through contract and MOU provisions. Each subsequent year this model will be re-evaluated using a PDSA process.

Timelines for Payments. Infrastructure, pay-for-outcome, and pay-for-reporting payments will be expended and then the County will receive federal reimbursement. Fee-for-service payments will be paid through the City's regular periodic invoicing process, although the contracted payment schedule may be structured to coincide with the timing of the federal payments. Per-member-per month payments will be made quarterly using payment estimates, then reconciled to actuals at the end of the year once final reporting is available. All payment schedules will be established between DPH and partner agencies through contracts, MOUs, and work order agreements.

Alignment with Other Funding Sources. The proposed WPC pilot has been strategically designed to operate in close coordination with other major funding initiatives planned over the next five years. Application development was led by the City's 1115 Waiver Integration Team, which is coordinating San Francisco's strategy for implementing PRIME, GPP, Drug Medi-Cal Waiver, and Health Homes. In June 2016, San Francisco voters passed Proposition A, a $350 million General Obligation bond including funds to improve county health and homeless service facilities, improving capital infrastructure needed to drive outcome improvements for the target population. The Mayor's proposed budget introduced on June 1, 2016 includes $221 million in funding for the new Department of Homelessness and Supportive Housing. The WPC pilot will be closely coordinated and managed with these initiatives to maximize patient outcomes.

5.2 Funding Diagram (see attachment)

5.3 Non-Federal Share

The non-federal share will be provided by appropriation of City and County of San Francisco General Funds to the Department of Public Health as the lead entity. The non-federal share will be appropriated and provided using the same process as other programs requiring intergovernmental transfers of the non-federal share of funds.

5.4 Non-Duplication of Payments and Allowable Use of Federal Financial Participation

San Francisco currently has a rich array of services, and believes that the core service components are in place to drive improved health outcomes at reduced cost. However, many of these services are spread across multiple agencies and entities, resulting in a system of care that is imperfectly aligned to achieve results. The target population includes very sick, very high-cost, high-utilizing individuals who periodically receive services from many agencies.

Broadly speaking, the WPC proposal will: 1) establish information technology and operational infrastructure that will facilitate coordination across systems of care, and 2) use shared financial incentives and payment structures to establish a value-based, outcome-oriented mindset to multi-agency service delivery in San Francisco. These goals are directly consistent with STC 113's criteria for WPC pilot support. While San Francisco has identified a number of strategies to achieve these goals, until the WPC pilot these actions have not been reimbursable under Medi-Cal or other federal funding.

There will be a number of processes in place to ensure federal financial participation will be received only for services provided to Medi-Cal beneficiaries and will not result in duplicative payments. The target population for the WPC proposal are the Medi-Cal eligible homeless San Franciscans who rely on the public healthcare services provided by SFDPH. The project will improve coordination of data systems across multiple agencies and organizations, including data on eligibility for Medi-Cal and other benefits. Each of the entities participating in the program has extensive experience and existing processes in place for tracking services and expenditures by insurance eligibility status to ensure compliance under federal reimbursement rules. DPH currently tracks eligibility for Medi-Cal through its electronic health record system and CCMS, and as a safety net provider has well-established processes in place to segregate services and costs based on eligibility status. DPH does not participate in the targeted case management program and DHCS will be removing San Francisco from the State Plan Amendment. Both San Francisco Health Plan and Anthem Blue Cross, the two county Medi-Cal plans, are participating in the program. HSA is the county agency designated for Medi-Cal enrollment. Data on services provided under the proposed pilot, including Medi-Cal eligibility status, will be closely tracked and reported throughout the life of the pilot. In cases where services proposed under the pilot will benefit both Medi-Cal eligible and ineligible clients, the estimated costs and reimbursement assigned to the WPC program have been pro-rated to ensure that WPC funds serve only the eligible portion of the population, with the balance assigned to City and County General Funds or other non-federal sources.

As a part of the governance structure for the pilot, participating agencies will develop a memorandum of understanding (and associated contractual language where applicable) that will include a requirement that entities receiving payment of federal funds must document eligibility status for service recipients. Where funds are provided on a fee-for-service, capitated, incentive and outcome basis, data on Medi-Cal eligibility will be required before payments are distributed to ensure federal funds are not used for services to individuals ineligible for Medi-Cal.

5.5 Funding Request

See attached budget worksheet

Budget Justification

San Francisco's Whole Person Care Pilot program (WPC Pilot) proposes to create a comprehensive, coordinated, and sustainable Multi-Agency Care Coordination System (MACCS) within the City and County of San Francisco to increase collaboration among, access to, and appropriate utilization of services and supports for homeless adults in San Francisco who are high utilizers of urgent and emergent care. An examination of San Francisco's system of care reveals a strong and wide foundation of services and data, but a siloed and inadequately coordinated service delivery structure that limits potential to drive patient outcome improvements.

Our proposed WPC pilot budget addresses the gaps in coordination, information technology infrastructure, and service and will allow us to provide more effective care for our homeless clients.

For services provided by City agencies using civil service employees (indicated with a four digit job class), growth in fee-for-service and PMPM reimbursement is included to cover wage and benefit cost increases governed by existing labor contracts. Where these services will be provided beyond the term of existing labor contracts, we used the projected growth rates assumed in the City and County of San Francisco's adopted 5-Year Financial Plan. For services provided by contracted partner vendors, increases in rates are based to negotiated increases in existing vendor contracts for similar services or, where no existing contracts are in place, based on growth rates assumed in the City and County of San Francisco's adopted 5-Year Financial Plan for contracted services.

San Francisco plans to use WPC Pilot funds to pay for the program for Medi-Cal beneficiaries; however, the City will cover any program costs for non-Medi-Cal beneficiaries who are homeless. Data in the CCMS database indicates that approximately 10,000 San Franciscans (who touch DPH systems) in a given year experience homelessness. An additional 6,954 individuals are believed to be experiencing homelessness but are not identified as such in CCMS or do not have a CCMS record, for 16,954 people. Of those, we estimate that up to 11,189 are Medi-Cal eligible. Therefore, many aspects of our budget will use a reduced rate of 66%.

Administrative Infrastructure

The **Administrative Infrastructure** will oversee the entire WPC Pilot program. The Administrative team is responsible for financial management and developing and administering the governance structure. Our proposal includes 6.5 FTE of operations staff to oversee the management, operations, evaluation and quality improvement critical to the success of our whole person care pilot:

A 0953 **WPC Coordinator (.5 FTE)** provides oversight of the entire project. He/she is responsible for convening partners, overall decision making, program design, operations, implementation, policy development, staff recruitment and supervision, budgeting, program monitoring and reporting, and liaison with the state, partners and other stakeholders.

The 0923 **WPC Operations Manager** (1 FTE) oversees day to day operations of the WPC Pilot, provides supervision of line staff, convenes and staffs the various steering and subcommittees, coordinates trainings, monitors deliverables, oversees data development, information and communication, and operationalizes program design and policies.

The 1406 **Administrative Support** (1 FTE) supports day-to-day office functions for the WPC team, including scheduling meetings, calendaring, preparing agendas and meeting minutes, maintaining records, ordering supplies and requisitions, preparing reports, and supporting trainings activities.

The 2803 **Epidemiologist II** (1 FTE) will examine data at a population level to determine patterns to assist with targeted services. This position will be key to creating and implementing a universal assessment tool and risk stratification tool.

The 2119 **Quality Improvement Analyst** (1 FTE) is responsible for developing a quality plan, collecting and analyzing data, developing dashboards, designing performance improvement activities, coordinating PDSAs, guiding program monitoring, evaluation and audits, identifying training needs, coordinating trainings as appropriate, and liaising with external evaluator.

The temporary **Finance/Admin Staff** (1 FTE) will be hired for the duration of the WPC pilot to support the initial set-up and implementation of WPC financial and administrative systems and policies. Given the time to hire new staff, the proposal includes 0.2 FTE in PY2 to account for the recruitment and hiring process.

The 1823 **WPC Policy Analyst** (1 FTE) documents WPC-related policies and procedures, including business processes for Coordinated Entry, and services and data entry protocols for Street Triage, Enhanced Housing Transition and Housing & Tenancy Stabilization. Given the time to hire new staff, the proposal includes 0.2 FTE in PY2 to account for the recruitment and hiring process.

Salary and mandatory fringe benefits costs for this team and other administration infrastructure costs are summarized in the table below (Round 2 changes in highlighted in bold).

		PY2 2017	PY3 2018	PY4 2019	PY5 2020
Administrative Infrastructure					
Item	*Annual Max Units*	*Max WPC Fund Amount*	*Max WPC Fund Amount*	*Max WPC Fund Amount*	*Max WPC Fund Amount*
ADMINISTRATION					
0.5 FTE 0953 WPC Coordinator Salary	0.50	$ 90,168	93,324	96,590	99,971
0953 Fringe	0.50	$ 30,542	31,610	32,717	33,862
1.0 FTE 0923 WPC Operations Manager Salary	1.00	$ 134,576	139,286	144,161	149,207
0923 Fringe	1.00	$ 52,098	53,921	55,809	57,762
1.0 FTE 1406 Adminstrative Clerk Salary	1.00	$ 59,462	61,543	63,697	65,927
1406 Fringe	1.00	$ 29,060	30,077	31,130	32,219
1.0 FTE 2803 Epidemiologist II Salary	1.00	$ 109,559	113,394	117,362	121,470
2803 Fringe	1.00	$ 42,326	43,807	45,341	46,928
1.0 FTE 2119 Quality Improvement Analyst Salary	1.00	$ 94,669	97,982	101,412	104,961
2119 Fringe	1.00	$ 38,402	39,746	41,137	42,577
Program Materials and Supplies	**1.00**	**$ 14,545**	**$ 21,446**	**$ 9,050**	**5,811**
Contracted Program Evaluation Costs	**1.00**	**$ -**	**$ 200,000**	**$ 200,000**	**$ 200,000**
1.0 FTE Finance/Admin Staff Temp	**1.00**	**$ 19,000**	**97,850**	**100,786**	**$ 103,809**
Finance/Admin Staff Temp Fringe	**1.00**	**$ 7,600**	**39,140**	**40,314**	**$ 41,524**
1.0 FTE WPC Policy Analyst	**1.00**	**$ 22,311**	**114,904**	**118,351**	**$ 121,901**
WPC Policy Analyst Fringe	**1.00**	**$ 8,925**	**45,961**	**47,340**	**$ 48,761**
WPC Training	**1.00**	**$ 45,000**	**180,000**	**170,000**	**$ 160,000**
Tablets, Software, Support	**1.00**	**$ 35,000**	**2,000**	**2,000**	**$ 2,000**
Travel for Meetings/Conferences	**1.00**	**$ 20,000**	**20,000**	**20,000**	**$ 20,000**

Program Materials and Supplies: Funds allocated to program materials and supplies will be spent on computers (approximately $2,000 each) and workstations (approximately $6,000 each) for new program staff, office supplies, training materials, and other costs associated with running the program. We have $14,545 in the PY2, $21,445 in PY3 and $9,050 in PY 4 and $5,811 in PY5 to support ongoing program expenses. We have also budgeted $35,000 in PY 2 to support the purchase, software installation and customization, and IT support of tablet computers to be used by WPC staff in the field with a lower ongoing renewal and software support level of $2,000 in PY 3 through 5.

Program Evaluation: DPH will contract to evaluate both processes and outcomes of the WPC Pilot. Quality Improvement and PDSA (Plan-Do-Study-Act/Adjust) are integral parts of the WPC Pilot so every component of implementation, including evaluation, will go through PDSA to make sure it is working. This is important to know what worked or did not to allow for institutionalization and spread. Our program evaluation contractor will design evaluation, develop and administer assessment tools, collect data, and prepare reports. Our proposed budget assumes $200,000 annually in PY3, PY4 and PY5 for these costs based on prior engagements with other consultants, although we plan to engage in non-cost PDSA activities in PY2. While the contract has not been created, our evaluations have included contracted cost for a program evaluator (at approximately $150,000 annually), additional interviewers (~$30,000) as well as

program costs for travel and supplies (~$20,000). Actual budget will be finalized with contract.

Training: The WPC Training team (contracted) will be hired to educate HSH and partner agency staff on WPC practices and interventions. Curriculum will include understanding homelessness, critical time intervention, trauma-informed care, progressive engagement, housing navigation, universal precautions, performance-based services, Medi-Cal billing practices, and Plan-Do-Study-Act. Application includes an initial cost of $45,000 in PY2 and annualizing to $180,000 in PY3 and an estimated $170,000 in PY4 and $160,000 in PY5 to account for lesser level of anticipate training in the last two years of the pilot.

Travel: An average of $20,000/year is included to support members of the WPC leadership team travel to attend conferences, DHCS-sponsored WPC learning collaborative meetings in northern and southern California, and other training and capacity-building meetings.

Delivery System Infrastructure

To fully support the WPC Steering and Operations Committees in their efforts to coordinate care across agencies and services, we must increase our capacity to collect, analyze and share information. Our delivery infrastructure proposal focuses on increased data and data sharing capacity through our Multi Agency Care Coordination System.

Multi Agency Care Coordination System (MACCS) Data Infrastructure

Data Platform

SFDPH currently has an Oracle database, Coordinated Care Management System (CCMS) that pulls data from 15 different sources. While CCMS is in many ways a powerful tool, it is limited in its ability to integrate data from other systems, and is not universally available to providers. San Francisco proposes to develop a more robust platform. The new platform will integrate CCMS with other critical data systems including the Homeless Information Management System (HMIS), Emergency Department Information Exchange (EDIE) and other systems into one interactive platform. This integrated system, known as MACCS, will provide a single shared source of actionable data to service providers at multiple agencies.

MACCS will enable development of a single multiagency assessment tool to develop risk stratification of patients to prioritize interventions citywide. We expect at least 200 providers will need access to this system, but we plan to review the actual needs as part of our evaluation process.

In order to support MACCS and ensure ongoing reporting capabilities, we propose five staff members to implement and manage this critical system as summarized below. Total costs are summarized below, but only 66% of the costs are included in our WPC application. These staff members will initially manage and help with the implementation costs for our new MACCS system. Once the MACCS system is implemented, their

work will shift to the day to day maintenance, training, minor enhancements and other necessary support to ensure data is accessible to all members of our team. The implementation cost will be reduced once the initial transition is complete.

			PY2 2017	PY3 2018	PY4 2019	PY5 2020
Item		*Max Amount Per U*		*Max Amount Per Unit*	*Max Amount Per Unit*	*Max Amount Per Unit*
MULTI AGENCY CARE COORIDINATION SYSTEM DATA INFRASTRUCTURE (MACCS)						
1.0 FTE 1070 IS Project Director Salary	HOM	$	155,554	160,998	166,633	172,466
1070 Fringe	HOM	$	47,304	48,960	50,673	52,447
1.0 FTE 1053 IS Business Analyst Salary	HOM	$	121,889	126,155	130,571	135,141
1053 Fringe	HOM	$	41,630	43,087	44,595	46,156
1.0 FTE 1044 IS Engineer Salary	DPH	$	155,554	160,998	166,633	172,466
1044 Fringe	DPH	$	47,304	48,960	50,673	52,447
1.0 FTE 1042 IS Engineer Salary	DPH	$	130,477	135,044	139,770	144,662
1042 Fringe	DPH	$	43,078	44,586	46,146	47,761
1.0 FTE 1823 Data Integrity Anayst Salary	DPH	$	130,477	135,044	139,770	144,662
1823 Fringe	DPH	$	20,083	20,786	21,513	22,266

The 1070 **IS Project Director** (.66 FTE) is the Whole Person Care IT Applications Supervisor. He/she will work collaboratively with clinical and operational leaders throughout DPH to provide whole person care application support and solutions to meet both the business and technical needs of DPH. This position plays a key role in the ongoing implementation and integration of electronic health technology in support of DPH's whole person care, regulatory, clinical and financial goals.

The 1053 **IS Business Analyst (Senior)** (.66 FTE) oversees the more difficult and complex aspects of the systems/application services development cycle, including needs analysis, cost-benefit analysis, structured systems analysis and design, feasibility analysis, technology and software assessment, telecommunications needs analysis, project planning and management, system installation, implementation and testing, conversion to production status, technical and procedural documentation, user training, and post-implementation assessment and administration. He/she is a primary IT resource for an organization with a complex system.

The 1044 **IS (Technical or Applications) Engineer – (Principal)** (.66 FTE) provides direct ongoing supervision to other IS Applications/Technical Engineers. He/she provides leadership and direction and assumes technical responsibility for completion of major projects, and serves as the top technical or applications services authority for one or more related specialties. He/she also performs and reviews complex work involving analysis, planning, designing, implementation, maintenance, troubleshooting and enhancement of complex large systems or applications services consisting of a combination that may include application operating system support, and or mainframes, mini-computers, LANS, and WANs support. Additionally, he/she serves as the lead applications operating support or database administrator for database design, migration, performance monitoring, security, troubleshooting, as well as backup and data recovery.

Finally, the Principal Engineer serves as a database administrator and operating system support for applications services or technical architect and systems integrator for large complex systems.

1042 **IS (Technical or Applications) Engineer – Journey** (.66 FTE): Under general direction, this position, analyzes, plans, designs, implements, maintains, troubleshoots and enhances large complex systems, or application services consisting of a combination that may include application operating system support, database administration and/or mainframes, mini-computers, LANS, and WANs support. He/she serves as a database administrator and operating system support for applications services or technical architect and systems integrator for large complex systems.

The 1823 **Data Integrity Analyst** (.66 FTE) monitors CCMS data for duplicate records, consolidating and unmerging client records as needed, and reporting errors back to users and source systems, as well as for trends in data transfer for completeness and accuracy to assure files are being transferred as planned into CCMS and updating records. Working with IT, she/he prepares and uploads new datasets into CCMS database, and test for data integrity. She/he monitors proper linkage and functioning of the Patient Summary through DPH source systems (Avatar, eCW, Invision) and runs quality management reports at designated time intervals. Finally she/he audits user view histories and submits reports to Privacy Officers as needed.

The implementation and operating costs are based on a preliminary estimate from a consultant and are comprised of the following. This table represents our projection the total costs, of which 66% of the costs are reflected in our application.

		PY2 2017			PY3 2018			PY4 2019			PY5 2021		
Item	*Dept*	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
MACCS SYSTEM DEVELOPMENT AND SUPPORT													
Interface Cost Uni-Directional	DPH	16,000	2.00	32,000	16,000	2.00	32,000	16,000	2.00	32,000	16,000	2.00	32,000
Interface Cost Bi-Directional	DPH	32,000	6.00	192,000	32,000	6.00	192,000	32,000	6.00	192,000	32,000	6.00	192,000
Contracted Implementation Costs	DPH	400,000	5.00	2,000,000	400,000	5.00	2,000,000			-			-
Software License - Mule Soft	DPH	100,000	1.00	100,000	100,000	1.00	100,000	100,000	1.00	100,000	100,000	1.00	100,000
Software License - Wave per system	DPH	1,170	10.00	11,700	1,170	10.00	11,700	1,170	10.00	11,700	1,170	10.00	11,700
Software User License - Health Cloud per users	DPH	2,200	100.00	220,000	2,200	200.00	440,000	2,200	200.00	440,000	2,200	200.00	440,000
IT Contingency	DPH	100,000	1.00	100,000	100,000	1.00	100,000	100,000	1.00	100,000	100,000	1.00	100,000
Subtotal All Costs				2,655,700			2,875,700			875,700			875,700

Our goal is to connect multiple systems throughout CCSF together onto the MACCS platform. Over the course of the first two pilot years, we aim to integrate five systems – two uni-directional going from original source system into MACCS and three bi-directional between original source system and MACCS. In total, there will be eight interfaces created involving 5 source systems with MACCS. Industry standard estimates each interface set up to cost approximately $16,000 to $32,000 depending on complexity. Costs includes for software licenses for Wave and Mule Soft to normalize our data to facilitate end users access to MACCS to drive care coordination. For the pilot phase we anticipate 100 cloud user licenses to access MACCS at $2,200 per license.

Health Plan Reporting Infrastructure

As part of supporting San Francisco's WPC Pilot program, SFHP will partner with WPC Pilot partners in the data integration effort by offering/using PreManage, an integrated patient-centric software that allows for real-time clinical insight of Health Homes & WPC participants and that will align with MACCS. Part of this effort to provide an integrated clinical data sharing portal entails data integration from SFHP for its existing members. This initiative will require leveraging consultants and internal staff to lead overall project management to establish SFHP WPC requirements, including aligning multiple systems and data exchange between various participating entities (providers, members, plans). In addition, SFHP will provide ongoing financial, clinical and other reporting and monitoring as required under the pilot by the project sponsors and participants. There will be no duplication of reimbursement for reporting that is already required for Medi-Cal.

Health Plan Data Infrastructure Costs for Whole Person Care

Health Plan Data Infrastructure Co	# OF FTE	Cost + 33.5% Benefit (FTE)				
Job Title	**FTE**	**PY2 2017**	**PY3 2018**	**PY4 2019**	**PY5 2020**	**Purpose and Comment**
Project Management	1.0	$280,000				To initiate and lead the initial organization of the WPC pilot for all affected departments of the Health Plan (Finance, ITS, Health Services, Operations, BI, etc.), including establishing the Health Plan WPC program requirements based on the approved plan, workflows, distribution of departmental responsibilities, timelines, etc.
ETL Developer	0.50	$91,978	$0	$0	$0	The WPC pilot will introduce a new data source (PreManage data) that must be integrated into the health plan's Enterprise Data Warehouse. This will allow the PreManage data to be integrated with the health plan's existing patient member data, thus achieving the goal of the WPC pilot to gain a full/holistic view of the patient with all data sources present. To achieve this integration requires an ETL developer to take the data, transform and integrate it in order to move it into EDW.
IT Project Manager	0.50	$121,243	$0	$0	$0	A technical ITS project manager is required to ensure that the programmatic requirements/business needs and processes for WPC are translated and aligned with the Health Plan's systems and ITS infrastructure.
Report Developer	0.50	$52,086	$80,072	$82,474	$84,949	ETL and reporting support for data analysis & reporting to DPH and any other regulatory agencies
EDI Analyst	0.50	$58,431	$89,827	$92,522	$95,298	Data exchange support, trading partner management
Production Support Specialist	1.00	$75,514	$77,780	$80,113	$82,517	Ongoing support of data exchange set-up (SFTP), technical support, internal staffing support
ITS Accountable Manager	0.10	$12,591	$19,357	$19,938	$20,536	The ITS accountable manager oversees the entire project team and handles escalated issues and ensures overall quality. The ITS Accountable Manager will be the point person/point of accountability for the overall project and directly to the DPH.
QA Analyst	0.25	$21,514	$33,073	$34,065	$35,087	Before enacting any changes related to PreManage or using the data from the WPC pilot, it must be validated and tested. The QA Analyst ensures the overall quality and data validation in order to support this, including building test plans, test cases and providing testing support.
System Administrator/DBA	0.25	$29,575	$45,467	$46,831	$48,236	The Systems Administrator/DBA ensures that all Health Plan systems necessary to support the WPC pilot are maintained and are available on a 24/7 basis. This includes supporting integration, back-up, recovery, deployment to maintain this 24/7 availability.
BI Analyst (allocation to WPC)	0.25	$24,670	$37,926	$39,063	$40,235	The WPC pilot will require significant analysis and reporting of financial and clinical data. This will require approximate .25 of an existing FTE.
FTE Equipment	*2.0*	*$3,000*	*$0*	*$0*	*$3,000*	Estimated equipment cost; refresh every 3 years
Hardware/Software		*$50,000*	*$50,000*	*$50,000*		This is the estimated costs for acquiring servers, data storage, software acquisition and licensing, as well as ongoing maintenance.
Subtotal Costs		**$820,603**	**$433,502**	**$445,007**	**$406,857**	

Van with a Lift

Finally, the one-time cost of a van with a lift will be used to transport patients exiting **urgent/emergent services**. The calculated cost is two-thirds of the cost of a full price

"Chevy Express" van as the van will only be used 66% of the time for the eligible Whole Person Care population.

Delivery Infrastructure Costs added in Round 2

PY 2 Onetime Resource Center

Furniture, Furnishings, and Equipment (FFE) and Minor IT Infrastructure.

In anticipation of the 24/7 resource center opening in PY3, the delivery infrastructure items accounts for the one-time costs in PY2 to adequately outfit the projected 20,000 square foot space for round-the-clock client utilization including areas for rest, programmatic activities, dining, and staff working space and confidential staff-client areas to engage in service connection and coordination. The one-time costs for the entire center are estimated at $320,000, with 66% or $211,200 being eligible for WPC as detailed below:

Furniture, furnishings and equipment and minor IT infrastructure at a total cost of $211,200 with 66% proration include:

Medical grade recliner (50) at cost of $105,600 with 66% proration.

Community area chairs (100) at cost of $7,303 with 66% proration.

Reach-in Refrigerator (2) at cost of $4,720 with 66% proration.

Reach-in freezer (2) at cost of $4,803 with 66% proration.

Dining/community area at cost of $23,100 with 66% proration.

Staff cubicle set-up (10) at cost of $52,800 with 66% proration.

Client lockers (25) at cost of $7,405 with 66% proration.

Freight in at cost of $5,468 with 66% proration.

Start-Up Recruitment, Hiring and Training Costs (PY2)

Additionally, in order to open in PY3, SFHSH expects to incur one-time costs of approximately $209,545 (of which 66% of the total estimated cost of $138,300 is WPC eligible) to contract with community-based providers to operate the new Resource Center. These costs include funding the selected nonprofit provider to recruit, train and hire 24/7 staff and ensure providers can begin to ramp up operation prior to its opening in PY3.

Total cost of $141,400 for Resource center start-up costs

WPC Resource Center Start-Up Costs	
Salary and Fringe Benefits: (40 Day Ramp Up Costs)	
1.0 FTE Program Director Salary	9,167
40% fringe	3,667
2.0 FTE Onsite Social Workers Salary	13,933
40% fringe	5,573
2.0 FTE Center Managers	11,733
40% fringe	4,693
8.0 FTE Desk Staff/Coordinated Entry Check-in	38,133
40% fringe	15,253
4.0 FTE Support Staff	17,014
40% fringe	6,802
1.0 FTE Facilities Supervisor	5,725
40% fringe	2,290
1.0 FTE Facility Support	5,298
40% fringe	2,119
Subtotal Salary and Fringe Benefits (less janitorial services)	141,400
Recruitment and Training	
Est. Recruiting Costs/Background Checks (based on current City contracts)	10,000
Estimated Staff Training (based on current City contracts)	3,145
Estimated Rent Deposit (Based on 1 month rent deposit)	55,000
Total	209,545
66% for WPC eligible	**138,300**

Two Extended Passenger Van in PY 2

The van will be utilized by the RTCN staff to provide transportation from encampments to shelter, navigation centers, and treatment facilities. As encampments will be visited by at least three staff at a time, and have a large amount of client goods to transport, passenger vans with a minimum capacity for 6 will aid in resolving encampments as soon as residents are ready to transition indoors.

Each van is estimated at $50,000 purchase price. For two vans totaling $100,000, SFHSH has proposed a $66,000 WPC cost based on 66% eligibility.

The application also adds one SFHSH WPC manager in PY 2- PY 5. This position is 100% funded as WPC dedicated full-time to implementing HSH's portion of the WPC pilot including program oversight, outcomes, data and performance. The cost for this

position is $129,000 for salary and $51,600 fringe benefits in PY 2 at only 20% due to the time to hire the position in PY 2. PY3 costs total $129,000 for salary and $51,600 for fringe or 100% of cost. PY4 costs total $132,870 for salary and $53,148 for fringe or 100 % of the cost (including 3% CCSF COLA, per union labor agreement). PY5 costs total $136,856 for salary and $54,742 for fringe or 100% of the cost including 3% CCSF COLA, per union labor agreement)

Incentive Payments

PY2 Incentives are detailed in the table below.

Incentive Payments				
Item		*Max Amount Per Ui*	*Max Units*	*Max WPC Fund Amount*
Open Four Navigation Centers	HOM	$ 500,000	2.00	$ 1,000,000
CAPACITY BUILDING INCENTIVES				
Social Detox to become Drug Mcal Certified	DPH	$ 400,000	1.00	$ 400,000
Medical Detox to become Drug Mcal Certified	DPH	$ 400,000	1.00	$ 400,000
Future Capacity Building Incentives based on PDSA - DPH (actual dept TBD)	WPC			
Develop universal tool assessment, outcomes viewable by clinicans and patient - DPH Providers	WPC	$ 325,000	1.00	325,000

A new incentive payment is requested in Round 2 application in PY3

PY 3 includes an additional incentive to open a Resource Center shown on highlighted in bold in table below. In order to encourage the timely opening of the center, an incentive payment of $500,000 for the single center is included.

Incentive Payments			
Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Open Four Navigation Centers	500,000	1.00	500,000
Open One Resource Center	**500,000**	**1.00**	**500,000**
CAPACITY BUILDING INCENTIVES			
Future Capacity Building Incentives based on PDSA - DPH (actual dept TBD)	440,000	1.00	440,000

Opening Navigation Centers

San Francisco opened its first navigation center in 2015. The Navigation Center created a model for engaging with long-term homeless individuals with barriers to utilizing the traditional shelter system and accessing care to drive outcome improvements. The Navigation Center brings together services and staff from multiple City agencies and non-profit partners to streamline the processes by which homeless individuals connect to benefits and exit into stable housing. The Center is a 24-hour, low threshold facility that allows clients to enter with their partners, possessions, and pets. In our first year of operations, we served over 450 clients. It is innovative because it is a resource center during the day and shelter at night unlike other shelters which close during the day.

We believe that this new model provides an important method of stabilizing our clients and preparing them for the next phase of housing. Additional Navigation Centers opened by the Department of Homelessness and Supportive Housing will be critical to serving our target population. To incentivize the timely opening of additional centers we are including incentive payments of $500,000 per new center. Payment is triggered when the new Navigation Centers open to clients. The lead agency will receive the payment and transfer to HSH by established protocol. The pilot projects opening two new centers in PY2, a third in PY3, and a fourth in PY4.

Opening a Resource Center

As part of on-going innovations to access, support, and stabilize homeless individuals, SFHSH projects opening a resource center (described more extensively below in Fee for Services) in PY 3 (2018). In order to encourage the timely opening of the center, an incentive payment of $500,000 for the single center is included.

San Francisco continues to have insufficient shelter and housing resources to meet the needs of its unsheltered population. HSH proposes new strategies to provide respite and service connection to people living on the street. In 2018, the Department has plans to open a 24-hour/7 days-a-week resource center where people experiencing homelessness can access restroom facilities, take showers, receive services, and enroll in county benefit programs. HSH proposes using the resource center to provide care coordination for the City's chronic homeless population leveraging funding through the Whole Person Care pilot. Within the center, clients will be assisted by staff who conduct triage and assessment work to enter them into Coordinated Entry, and will receive care coordination assistance in making connections to medical and behavioral health care. On any given day, San Francisco has more than 6,000 homeless residents. Currently, there are over 1,000 shelter and navigation center beds each night, but that leaves several thousand with no place to go. While HSH brings on additional shelters, navigation centers, and supportive housing units, a Resource Center will be established to provide brief assistance to people living on the streets or in emergency shelters. The Resource Center will be open 24 hours, but will not have or require reservations like

Navigation Centers and emergency shelters do. There will be places to rest, but the resource center does not function as a sleeping place.

In addition to seating areas, the Resource Center will have on-site social workers to assist people who need immediate social services. While some people living on the streets are connected to case management, those services have more limited hours and their staff cannot always locate clients as encampments and solo campers move frequently.

The Resource Center will open in PY3, and remain open through PY5. This is proposed to WPC as a Fee for Service, and will track the number of unduplicated beneficiaries accessing the center on a daily basis, with 150 daily encounters at 66% eligibility.

Capacity Building in Detox Programs

Persistent and acute substance use disorders prevents many of our clients from permanently exiting from the cycle of homelessness and housing. To incentivize two of our major community partners, HealthRIGHT 360 and Baker Places, to improve their service delivery and infrastructure, we propose an incentive payment of $400,000 each to become Drug Medi-Cal (DMC) Certified. This certification will also lead to better clinical outcomes and long term financial sustainability for these organizations. Payment is triggered when DMC certification is received and billing can begin. Payment is first received by the lead agency and then transferred into the city contracts of the down-stream non-profit organizations that will receive the incentive.

Future Capacity Building Incentive Payments

As part of our evaluation and PDSA process we will identify future goals for our downstream providers. We set-aside funding amounts of $440,000, $820,000, and $430,000, in pilot years 3, 4, and 5 respectively. PDSA will occur in PY2 as well, but it does not become incentivized until subsequent years. Possible uses of this funding can include evaluating and boosting day-time activities in the Navigation Centers, implementing medication management options in homeless shelters, and strengthening case management follow-up for individuals newly housed in independent living situations. Payment will be triggered by satisfactory completion of the PDSA and will go to the agency providing the service being evaluated.

Increasing Data Usage

Developing an electronic data infrastructure is only valuable if it is used by the provider community and if there is a standard for data collection. There is a one-time incentive of $325,000 in PY2 for the development of a universal assessment tool. Finally, completing and updating universal assessments for all homeless persons is a data use activity that needs everyone's participation. Variant metric 1 is included in pay for reporting and pay for outcomes to incentivize completion of health and social assessments with all homeless persons. Payment will be structured the same pending completion of the tool.

Fee for Services

Dual Diagnosis Residential Treatment

DMC/ODS residential treatment is limited to 90 days per admission, up to two admissions per year. Some of our patients may need longer or more frequent episodes of care, especially those who cannot find safe step-down housing where they can consolidate their recovery gains.

Dual Diagnosis (Substance Use & Mental Health) and Substance Abuse Residential Treatment are critical to stabilizing our clients with behavioral health issues. Under the new Drug Medi-Cal waiver, payments for residential treatment are limited to stays of up to 90 days. However, for some of the most complex clients in the target population, data indicates that extended stays of up to 180 days may reduce recurrence or avoidable negative health outcomes following treatment.

Costs for this service were based on existing contracts and rates of $300 per day for mental health dual diagnosis and $140 a day for substance use. This will provide up to 25 targeted clients at any given time up to an additional 90 day of treatment each in both dual diagnosis (mental health and substance use) treatment and substance abuse treatment for a maximum of 2,250 days provided in a given PY.

Medical Respite Expansion

Medical Respite services are currently provided through a contract between the Department of Public Health and a non-profit service provider. The costs included in the WPC budget for the expansion services are based on the existing contract in place for medical respite services, pro-rated by the proportion of beds expected to be used by the Whole Person Care population. The DPH budgets contracted services in a single line-item, so the projected total payment to the contracted provider is included here. A description of the planned services provided is included in Section 3 of the WPC application under “Innovations in Service.”

The operating and nonclinical support of medical respite will be provided by Community Access and Treatment Services (CATS), a community based organization and expected to cost $1.9 million annually as detailed below. Our FFS rate reflects 66% of these costs based on our expected Medi-Cal Eligible population.

WPC Medial Respite Expansion Costs	
Salary and Fringe	
1.0 FTE Program Coordinator	33,496
1.0 FTE Senior Janitor	19,777
1.0 FTE Cook	22,574
0.2 FTE Program Director	8,613
1.0 FTE Driver	21,341
10 FTE Respite Worker	218,746
43% Fringe	139,556
Subtotal Salary and Fringe	464,104
Occupancy:	
Rent	344,168
Utilities(telephone, electricity, water, gas)	40,986
Building Repair/Maintenance	34,155
Materials & Supplies:	-
Office Supplies	68,686
General Operating:	-
Training/Staff Development	27,324
Insurance	20,493
Equipment Lease & Maintenance	34,155
Staff Travel:	-
Parking	3,279
Consultant/Subcontractor:	-
Professional Consultants - Audit	4,782
Other:	-
Client Related Costs	54,648
Food & Food Preparation	68,310
Advertising	2,732
	-
Subtotal	1,167,821
5% Indirect	58,391
TOTAL OPERATING EXPENSE	1,226,212

We expect the new center to be operational in early 2017, but have prorated the annual operating costs in PY2 to 75% to reflect potential delays in fully operationalizing this new facility. The rates assume full annual amount of operations in subsequent years. Our daily rate is calculated below:

Rate Calculation for Medical Respite FFS	
Beds	25
Days	365
Annual Number of Units (Beds X Days)	9,125
Annual Base Costs	$ 1,226,212
Rate (Annual Costs/Number of units)	$ 134.38

Resource Center

This FFS covers 24-hour staffing at a new resource center that will provide a safe space for services, basic assistance with hygiene, a place to rest, and walk-in care connection support for WPC members. Members will be able to access Coordinated Entry, on-site social services, and connections to medical and behavioral health providers. Clients may access the Resource Center during the day while waiting for shelters to open in the evening, or for those who are staying on the street at night, a place to come inside and warm up on a cold or wet night. Services will be offered during daytime and evening hours. Each entry/encounter in a Resource Center will be tracked using ONE System data.

Rates are calculated by taking 66% of the annual costs to operate the center and dividing by the expected number of resource center encounters (150/day) by the WPC eligible population (99). Average number of monthly encounters (visits to the Resource Center where the client is registered in the ONE System and offered services) are calculated by overlaying WPC eligibility: 150 per day x 365 x 0.66 eligibility, divided by 12 months. The staffing ratio for supportive services is 1 to 15. This staffing level includes the two social workers and the 8 desk/check-in staff who assist with resources and referrals, coordinated entry check-in, and shelter reservations. The remainder are facilities staff monitor safety, clean the site, and oversee the center.

Rent is estimated at $50/square foot for 20,000 square foot equaling $1,000,000. Taking 66% of the annual cost equals a cost of $660,000 for WPC.

Utilities costs of $187,873 annually are based on current budgets of similar size facilities of approximately $15,656.08 per month.

Building Repair/Maintenance Supplies of $103,500 are based on current budgets of similar size facilities of approximately $8,625 per month.

Security costs of $600,000 are based on an average per shelter cost of existing City security contract of $50,000 per months.

Client Supplies and services costs of $73,714 annually are based on City contract for toiletries, blankets, laundry and supplies at $6142.83 per month.

The cost of this service is based upon an estimated 36,135 annual units (encounters) of service x $83.35 = $3,011,852. The calculation of units of service was based on the assumption of 3011 encounters per month in PY 4-5. In PY 3 it is projected the Resource will open in February and a total of 32,250 encounters due to start up timing. The Resource Center opens in PY3, therefore PY 2 does not include Resource Center operating costs.

Resource Center start trigger: a person without stable housing comes into the resource center for any of the services available there

Resource Center end trigger: Placement in Navigation Center or Housing Stabilization Bundle

Length of service: 1 day – 12 months

Anticipated total member days: 36,135 member days (since this is FFS and therefore based on point in time or daily encounters, member months is not real, so using member days as proxy. Average number of monthly encounters (visits to the Resource Center where the client is registered in the ONE System and offered services) are calculated by overlaying WPC eligibility: 150 per day x 365 x 0.66 eligibility, divided by 12 months = 3,011 member months)

Anticipated number of unique individuals served: 5,148

Care ratio: 1:15

WPC Resource Center Costs		
Salary and Fringe Benefits:	66% WPC Eligible Costs	Total Costs
1.0 FTE Program Director Salary	82,500	125,000
40% fringe	33,000	50,000
2.0 FTE Onsite Social Workers Salary	125,400	190,000
40% fringe	50,160	76,000
2.0 FTE Center Managers	105,600	160,000
40% fringe	42,240	64,000
8.0 FTE Desk Staff/Coordinated Entry Check-in	343,200	520,000
40% fringe	137,280	208,000
4.0 FTE Support Staff	153,120	232,000
40% fringe	61,248	92,800
6.0 FTE Janitorial Staff	205,968	312,073
40% fringe	82,387	124,829
1.0 FTE Facilities Supervisor	51,528	78,073
40% fringe	20,611	31,229
1.0 FTE Facility Support	47,686	72,252
40% fringe	19,074	28,901
Subtotal Salary and Fringe Benefits	1,561,003	2,365,156
Occupancy		
Rent	660,000	1,000,000
Utilities	123,996	187,873
Building Repair/Maintenance Supplies	68,310	103,500
Security	396,000	600,000
Subtotal Occupancy	1,248,306	1,891,373
Client Supplies and Services		
Client Supplies (Blankets, Toiletries, Laundry-related costs) *based on current City contract*	48,651	73,714
Subtotal Services	48,651	73,714
Other		-
Office Supplies	10,471	15,865
Subtotal Other	10,471	15,865
		-
Subtotal Resource Center Costs	2,868,431	4,346,107
Indirect (5%)	143,422	217,305
Total Resource Center Costs	**3,011,852**	**4,563,413**
*Annual costs reflects 66% of costs based on expected MediCal Eligible Population		
Rate Calculation for Resource Center		
Annual Number of Encounters (150/day x 365 x .66 WPC)	36,135	
Annual Base Costs	$ 3,011,852	
Rate (Annual Costs/Number of Units)	$ 83.35	

Coordinated Entry

Coordinated Entry services for persons experiencing homelessness will be provided in collaboration with all WPC interventions. Coordinated Entry specialists will travel with the HOT Team, will visit encampments with RTCN, and will work with clients in Navigation Centers, Resource Centers, and in shelters.

Rates are calculated by taking 66% of the annual costs of administering the full assessment and prioritization tools for all clients, prorated for predicted WPC eligibility.

Under WPC, Coordinated Entry specialists will travel with HOT, conducting immediate intakes into the ONE system, and assessing people's eligibility for services, shelter, and housing options. This data will be shared with DPH, to immediately access care coordination assistance.

Roving Team services seek out people who are in the top tier of eligible clients for supportive housing, helping them prepare for housing placement. They work with approximately 25 clients at any given time. The roving team consists of 2 case manager FTEs, at a cost of $277,575 annually or $150,319 eligible for WPC based on a 66% of cost allocation.

Transportations costs are for staff to utilize public transportation to places where homeless clients are residing. Transportation costs are based on 20 mobile staff x estimated $823.75 yearly transportation costs = $16,475.

The cost of this service is based upon an estimated 6,000 annual units (completed assessments) of service x $255.36 = $1,532,160. The calculation of 6,000 units of service was based on the assumption of 500 assessments completed per month in PY 3-5. In PY 2 we project a higher rate of enrollments and a total of 4,500 completed assessments for a total cost of $1,149,120. Coordinated entry will serve approximately 1,980 in PY 2 and 3,960 during PY 3-5.

Coordinated Entry FFS start trigger: Homeless person identified in need of supportive housing. Intake completed.

Coordinated Entry FFS end trigger: Inactive or placement into Housing Stabilization Bundle

Length of service: 1 week – 120 days

Anticipated total annual member months: in PY2 (1980 members served in 2nd half of PY2 divided by 6 months ~ 330 members served per month and therefor 330 members X 6 months = 1980 member months) and in PYs 3-5 (3960 members served in each of PY3, 4 and 5 divided by 12 months ~ 330 members served per month and therefore 330 members X 12 months = 3960 member months)

Anticipated number of unique individuals served over the life of the project: 13,860

Care ratio: 1:25 (Monthly clients seen = 500/20 staff.)

WPC Coordinated Entry Costs	
Salary and Fringe Benefits:	Costs
1.0 FTE Coordinated Entry Program Analyst	82,500
40% fringe	33,000
1.0 FTE Coordinated Entry Mobile Team Director	89,100
40% fringe	35,640
2.0 FTE Coordinated Entry Clinical Assessment Supervisors	165,000
40% fringe	66,000
6.0 FTE Coordinated Entry Specialists	263,319
40% fringe	105,328
9.0 FTE HOT Street Care Coordination - Contract Staff	223,306
40% fringe	89,322
3.0 FTE HOT Street Care Coordinate - HSH Staff	152,036
40% fringe	60,814
Subtotal Salary and Fringe Benefits	1,365,365
Other:	
Coordinated Entry Roving Team Contract - 2 FTE	107,371
40% Fringe	42,948
Transportation	16,475
Total Coordinated Entry Costs	**1,532,160**
*Annual costs reflects 66% of costs based on expected MediCal Eligible Population	
Rate Calculation for Coordinated Entry FFS	
Coordinated Entry Assessments Per Month	500
Months Per Year	12
Annual Number of Assessments completed	6,000
Annual Base Costs	$ 1,532,160
Rate (Annual Costs/Number of Units)	$ 255.36

Rapid Targeted Coordination and Navigation Team Services

RTCN interventions are intended to create a proactive approach to connecting with and serving individuals who are living on the street and in encampments. This is critical for serving hard to reach segments of the target population: finding individuals where they are staying; assessing their needs; and providing rapid response and linkage to urgently needed services.

Phase One begins with outreach when an encampment is calendared as next up for resolution. Once the encampment is placed on the Encampment Master Log, engagement begins. These are clients that typically would not be found elsewhere such as in shelters.

Phase Two consists of concentrated intense engagement for 21-42 days with a set end date for all encampment clients and continued characterization of their needs. Provision of treatment also begins during this phase with RTCN intake and release of information completion, connection to DPH health providers, and Navigation Center/emergency shelter move-ins. All encampment clients are offered shelter or navigation center services with maintenance of engagement and care coordination. Staff coordinates extensively with health, police, and public works to maintain safety of the clients.

During resolution, RTCN collaborates closely with other city departments (as necessary and appropriate) to close the campsite and assist remaining clients to places of safety and respite.

With additional staffing, RTCN will have capacity for two teams of three, addressing two encampments simultaneously, and engaging twice as many people with care coordination assistance. HSH expects to contact more than 120 people per month, at least 66% (80) of whom will be WPC eligible, through the expanded RTCN.

Eligibility for RTCN WPC assistance will be based on RTCN intake that includes screening questions for Medi-Cal eligibility and needed intake questions for WPC. Full assessments including housing assessment are completed with coordination with primary care, connections to on-site health fairs and nursing, referral for treatment, behavioral health triage, and connections to ongoing services. A service plan is developed for all encampment clients with crisis intervention and linkage to resources. RTCN services will be provided on a per-encounter basis, but Care Coordinators will work with clients until they are placed in shelter or housing, working with them on treatment options, where appropriate, on gathering needed documents, and on identifying a path to housing and safety.

This team will provide an average 121 encounters per day. As the actual time that the team spends at each encampment can vary and the team could visit more than one encampment in a day, our fee for service rate is calculated by expected annual costs of services for the WPC population divided by the expected number of visits. The calculation reflected below is 80 WPC x 20 days per month x 12 months x 0.66.

Transportation cost of $6,000 is for maintenance, insurance and gas associated with the utilization of the two extended passenger vans (costs are the vans are described in the Delivery Infrastructure section).

Rapid Targeted Coordination and Navigation equipment/supplies costs of $8,000 include $3,348 in annual WPC eligible costs for portable toilets and handwashing station for approximately 50 weeks of service and $4,652 for two Motorola APX4000 portable radios or similar models.

Mobile phone services includes $4,200 for monthly tablet data plans and phone carrier plans for 6 FTE. This FFS also includes legal services fees at approximately $3,500 annually for up to 20 hours related to Rapid Targeted Coordination and Navigation.

Printing costs of $2,000 are included for public notices and encampment resolution notices in accordance with CCSF ordinance and encampment resolution policies.

Legal services fees cost of $3,500 annually for up to 20 hours related to Rapid Targeted Coordination and Navigations.

FFS start trigger: Encampment is calendared as next up for resolution in Master Log

FFS end trigger: Referral to Navigation Center and/or shelter and/or Housing Bundle

Length of service: 3-6 weeks

Anticipated total member months (annually): 120 people per month X 66% X12 months = 950 member months

Anticipated number of unique individuals served over life of the project: 1440

Care ratio: 1/16 (330 people per month)

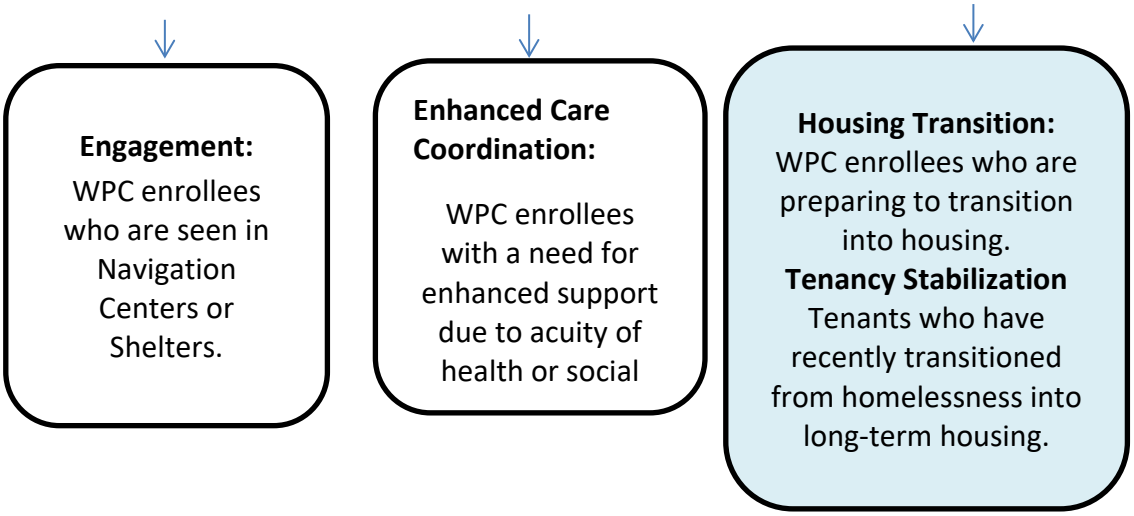
Annual WPC Rapid Targeted Coordination and Navigation Costs

Salary and Fringe Benefits:	Costs
0.6 FTE Shelter and Encampment Resolution Manager	59,500
40% fringe	23,800
0.6 FTE Street Triage Coordinator	49,500
40% fringe	19,800
1.0 FTE Encampment Response Manager	82,500
40% fringe	33,000
1.0 FTE Clinical Supervisor	99,000
40% fringe	39,600
4.0 FTE Care Coordinators/Encampments	171,600
40% fringe	68,640
Subtotal Salary and Fringe Benefits	646,940
Other:	
Equipment/Supplies	8,000
Transportation	6,000
Mobile Phone Services	4,200
Legal Services	3,500
Notices/Printing	2,000
Total Encampment Response Costs	**670,640**
*Annual costs reflects 66% of costs based on expected MediCal Eligible Population	
Rate Calculation for Encampment Response Team FFS	
Annual Client Encounters	12,672
Annual Base Costs	$ 670,640
Rate (Annual Costs/Number of Units)	**$ 52.92**

PMPM Bundled Services

San Francisco is proposing three bundled services rates for our Whole Person Care Pilot. These bundles will support a comprehensive continuum of response for San Francisco's homeless population, meet the evolving needs of the homeless population, and support transition from the street to housing.

Service Innovations Overview: The intent of the SF WPC pilot is that members progress toward having their health and social needs addressed and being stably housed (from left to right in this diagram); they may begin with any given entry point depending on the assessment and prioritization process. Members may receive services in the same PMPM bundle for multiple months depending on their needs and may "step up" or "step down" service profile depending on changing needs and circumstances.



PMPM rates are calculated by taking the total expected four year costs and dividing it by expected number of member months. This methodology allows us to create a stable rate throughout the course of the pilot.

Engagement Service Bundles

The first services are engagement services at our Navigation Centers and shelters. These are critical entry points for our population. Effective care services at these locations can engage those clients from the very beginning. Because these services are new innovations and lack an established model of fee-for-service payments, we believe a capitated model is appropriate. In addition, a PMPM structure will allow providers flexibility to use PDSA to adapt operating models to improve outcomes over time compared to a traditional payment system. A summary of our costs are shown below. As there is potential fluidity among clients to be at a shelter or a navigation

center, we have included these services as one bundled service.

Item	Dept	Cost	Cost	Cost	Cost	Four Year Total	
ENGAGEMENT SERVICES PMPM							
Navigation Center Staffing							
1950 Mission St	HOM	1,728,253	1,788,742			3,516,995	
Civic Center Hotel	HOM	1,423,011	1,472,817			2,895,828	
Dogpatch Nav Center	HOM	1,341,557	1,788,742			3,130,299	
Navigation Center 4	HOM	745,309	1,788,742	1,851,348		4,385,399	
Navigation Center 5	HOM	-	894,371	1,851,348	1,916,145	4,661,864	
Navigation Center 6	HOM			925,674	1,916,145	2,841,819	
1.0 FTE 0922 Navigation Center Coordinator Salary	HOM	84,880	87,851	90,926	94,108	357,764	
Navigation Center Coordinator Fringe	HOM	36,029	37,290	38,596	39,946	151,862	
Shelter Staffing							
2.0 FTE 2320 Registered Nurse Salary	DPH	$ 205,473	$ 212,664	$ 220,108	$ 227,811	866,057	
2320 Fringe	DPH	71,715	$ 74,225	$ 76,823	$ 79,512	302,275	
2.0 FTE 2586 Healthworker Salary	DPH	$ 88,077	$ 91,160	$ 94,350	$ 97,653	371,240	
2586 Fringe	DPH	38,141	$ 39,476	$ 40,858	$ 42,288	160,764	
						23,642,167	Total Four Year Co
						2,000	Total Members
						48	Total Months
						246.27	**Base PMPM Rate**

Services at the navigation centers will be provided by community based organizations. Currently, there are two Navigation Centers in operation - 1950 Mission St and the Civic Center Hotel. The annual operations costs of each site for all clients is around $2.5M. At 1950 Mission, approximately 60% of the contract costs go to support services, primarily in staff costs. At the Civic Center Hotel, approximately 50% of the contract costs go to support services. The remainders of the costs support property management expenditures including janitorial services, maintenance, leasing and utilities. The staffing model for the current facilities consist of 20.0-25.0 FTE Care Coordinators to provide 24-7 onsite in order to assess, prepare, and guide clients through benefits connection, housing applications, and barrier removal. The budget for our two current centers is provided below.

66% Annual Operating Costs for Civic Center Hotel Nav Center		
Salary and Fringe	**Costs in WPC Application**	Total Cost
1.0 FTE Building Manager	$ 47,520	$ 72,000
3.0 FTE Janitor Salaries	$ 49,500	$ 75,000
5.6 FTE Security -desk	$ 46,200	$ 70,000
1.0 FTE Maintenance Tech	$ 24,420	$ 37,000
1.0 FTE Maintenance Supervisor	$ 34,980	$ 53,000
0.05 FTE Director of Property Management	$ 3,536	$ 5,358
0.2 FTE Property Supervisor	$ 9,450	$ 14,319
0.1 FTE Program Assistant	$ 3,412	$ 5,170
0.1 FTE Director of Support Services	$ 6,707	$ 10,162
0.2 FTE Director of Clinical Services	$ 12,515	$ 18,962
0.3 FTE Clinical Services Manager	$ 14,359	$ 21,756
0.1 FTE Program/Partnership Manager	$ 4,669	$ 7,074
0.1 FTE Program Analyst	$ 3,218	$ 4,875
1.0 FTE Program Director	$ 49,500	$ 75,000
4.0 FTE Support Services Coordinator	$ 103,225	$ 156,402
1.0 FTE Support Services Supervisor	$ 37,703	$ 57,125
1.5 FTE Program Coordinator	$ 44,400	$ 67,272
3.0 FTE Intensive Services Coordinator	$ 96,691	$ 146,501
32-35% Fringe	$ 203,216	$ 307,903
Subtotal Salary and Fringe	$ 795,219	$ 1,204,877
Operations		
Rent	$ 269,280	$ 408,000
Utilities	$ 102,251	$ 154,926
Building Repair/Maintenance	$ 180,672	$ 273,746
Furnishing	$ 14,865	$ 22,522
General Operating		
Training/Staff Development	$ 14,879	$ 22,544
Insurance	$ 6,951	$ 10,532
Equipment/Supplies	$ 81,498	$ 123,482
Consultant/Subcontractor		
Professional Services/Accounting	$ 12,403	$ 18,792
Professional Services/Program Monitor	$ 155,106	$ 235,009
Other		
Client Supplies	$ 25,654	$ 38,870
Subtotal	$ 1,658,778	$ 2,513,300
5% Indirect (excluding lease)	$ 69,475	$ 315,795
Total Operating Expense	$ 1,728,253	$ 2,829,095

66% Operating Costs 1950 Mission Navigation Center	
Salary and Fringe	**Costs in WPC Application**
0.2 FTE Director of Shelters	$ 13,452
1.0 FTE Information & Resource Specialist	$ 25,837
1.0 FTE Site Manager	$ 44,349
1.4 FTE Supervisor - day	$ 42,290
1.4 FTE Supervisor - swing	$ 40,441
1.4 FTE Supervisor - night	$ 39,585
2.2 FTE Services Coordinator II - day	$ 48,616
3.2 FTE Services Coordinator II - swing	$ 70,821
4.2 FTE Services Coordinator II - Night	$ 93,362
0.5 FTE Services Coordinator II	$ 10,514
3.0 Care Coordinator	$ 78,030
1.0 FTE Lead Care Coordinator	$ 41,871
2.8 FTE Janitor - Day	$ 53,466
2.8 FTE Janitor - Day	$ 52,990
Replacement and Overtime	$ 114,478
	$ 770,101
45% Fringe	$ 346,563
Subtotal Salary and Fringe	$ 1,116,664
	$ -
Rent N/A City Owned	
Building Maintenance	$ 28,002
General Operating	`
Training/recruitment	$ 5,544
Insurance	$ 2,376
Equipment/Supplies	$ 11,266
Consultant/Subcontractor	
Client Services	$ 183,212
Other	
Client Supplies	$ 8,184
Subtotal	$ 1,355,249
5% Indirect	$ 67,762
Total Operating Expense	$ 1,423,011

Using the Civic Center Hotel as a model for future centers, we have projected the annual services and operations costs for the remaining three Navigation Centers to also be $2.5M annually and have included 66% of the costs or $1.78 million on the WPC application. The third center, the Dogpatch Navigation Center, is the process of site development with a planned opening in May of 2017 and a fourth in the South of Market neighborhood in early 2018. The remaining two centers are planned for FY 2018 and 2019. Operating costs in the first year of each centers operations are reduced to reflect partial year operations. Part of the Navigation Center model has been to take advantage of temporary physical spaces that are being underutilized. Both the 1950 Mission and Civic Center Hotel sites are slated on sites that will be converted into affordable housing in the near term and the Dogpatch Center is sited on a street. As such, future sites are currently assumed to be operational for a period of two to three years, but may be extended depending on specific site availability.

Actual level of services will depend on the final site locations, but we are committed to ensuring that Navigation Center Services are available to all our members for each of the pilot years.

San Francisco piloted the use of nurses in shelters in 2015 and experienced more than a 70% reduction in 9-1-1 calls. Given the success of the pilot, we are requesting to expand this service to additional shelters as nurses in shelters are not currently billable providers through Medi-Cal. We anticipate this program to further reduce emergency room visits and provide an enhanced level of care that is very much needed in our shelters. DPH will add 2.0 FTE registered nurses who will support clients in the shelters by providing care coordination, acting as a liaison with Medical Respite, medication management, consultations/orders, training shelter staff. To maximize the services of the nurses, 2.0 FTE Health Worker IIs will also be staffed with them in the shelters.

Enhanced Care Coordination Support

The second bundled payment is Enhanced Care Coordination. The onset of an Enhanced Care Coordination PMPM bundle begins by being homeless in San Francisco, being enrolled in Medi-Cal and receiving at least one enhanced care coordination engagement in the last 30 days. San Francisco will only receive bundled payments for individuals enrolled in the Pilot. The acuity of health needs varies during the entire engagement of a client and the intensity can vary depending on the client's present condition. Discontinuation of the PMPM bundle eligibility occurs when a person is housed for 6 months, has not received any enhanced care coordination services in the last 30 days or when he/she is dis-enrolled and/or no longer a Medi-Cal beneficiary. One quarter of this population primarily has needs for housing and skills development or workforce re-entry. Fifteen percent have housing needs and serious health chronic conditions. They are candidates for specialty services within the bundle. Staff: Client ratio in specialty services is 1:20.

Our application includes a care coordination team summarized below:

		PY2 2017	PY3 2018	PY4 2019	PY5 2020		
ENHANCED CARE COORDINATION SUPPORT							
1.0 FTE 2905 Eligiblity Coordinator Salary	HSA	83,710	$ 86,640	$ 89,672	$ 92,811	352,833	
2905 Fringe	HSA	37,764	$ 39,086	$ 40,454	$ 41,870	159,173	
1.0 FTE 1406 Sr Clerk for Eligiblity Salary	HSA	60,792	$ 62,920	$ 65,122	$ 67,401	256,235	
1406 Fringe	HSA	27,728	$ 28,698	$ 29,703	$ 30,743	116,872	
1.0 FTE 2908 Eligibilty Coordinator Salary	DPH	83,710	$ 86,640	$ 89,672	$ 92,811	352,833	
2908 Fringe	DPH	37,764	$ 39,086	$ 40,454	$ 41,870	159,173	
1.0 FTE 1824 Coordinated Entry Lead Salary	HOM	128,330	$ 132,822	$ 137,470	$ 142,282	540,904	
1824 Fringe	HOM	42,716	$ 44,211	$ 45,758	$ 47,360	180,045	
1.0 FTE 2593 DPH Clinical Services Lead Salary	DPH	110,273	$ 114,133	$ 118,127	$ 122,262	464,794	
2593 Fringe	DPH	39,540	$ 40,924	$ 42,357	$ 43,839	166,661	
1.0 FTE 2585 Outreach Team Specialist Salary	DPH	59,623	$ 61,710	$ 63,870	$ 66,105	251,308	
2585 Fringe	DPH	27,233	$ 28,186	$ 29,173	$ 30,194	114,786	
1.0 FTE 2586 Care Coordinator Salary	DPH	66,725	$ 69,060	$ 71,477	$ 73,979	281,242	
2586 Care Coordinator Fringe	DPH	28,895	$ 29,907	$ 30,953	$ 32,037	121,792	
1.0 FTE 2588 Health Worker IV Supervisor Salary	DPH	$ 77,991	$ 80,721	$ 83,546	$ 86,470	328,728	
2588 Fringe	DPH	$ 38,557	$ 39,906	$ 41,303	$ 42,749	162,517	
3.0 FTE 9910 Care Coordinators	DPH	$ 164,084	$ 169,827	$ 175,771	$ 181,923	691,608	
9910 fringe	DPH	$ 88,353	$ 91,445	$ 94,646	$ 97,958	372,406	
Contracted Care Coordination	HSA	825,411	$ 825,411	$ 825,411	$ 825,411	3,301,643	
Contracted Care Coordination	HOM	3,500,000	$ 3,500,000	$ 3,500,000	$ 3,500,000	14,000,000	
Client Supplies	DPH	300,000	300,000	300,000	300,000	300,000	
						22,675,553	Total Four Year Co
						1,500	Total Members
						48	Total Months
						314.94	**Base PMPM Rate**

DPH and HSA will enhance their eligibility staffing to better connect clients with services by adding two eligibility coordinators and one clerk.

DPH and the HSH will also provide one 1824 Coordinated Entry Lead, a 2593 Clinical Services Lead, a 2585 outreach team specialist ("engagement" specialists) and a 2586 additional care coordinator to provide additional care coordinator services.

We will also engage the Institute on Aging to provide care coordination to our most high-risk disabled or older clients with housing instability. This staffing will support 72 clients annually. DPH and the HSH will also provide one Coordinated Entry Lead, a Clinical Services Lead, an outreach (engagement) team specialist and an additional care coordinator to provide additional care coordinator services.

The WPC Pilot will employ centralized Contracted Care Coordinators who will be managed by the Coordinated Entry Lead. These care coordinators will collaborate with the client's primary case managers to develop a Community Care Plan. Focusing on the highest risk patients, the WPC Care Coordination Team will additionally:

- Remove barriers to facilitate timely connections to needed services, which may include medical care, conservatorship, intensive case management, mental health and substance abuse residential treatment;
- Ensure other providers are alerted to the client's elevated status;
- Dispatch engagement workers to locate individuals in the streets or pickup wherever they present; and

- Provide transitional or bridge case management services and continuously monitor the client until they are fully engaged in care.

As the elements of MACCS advance in their development, the WPC care team will have increased access to accurate and comprehensive information to connect clients with appropriate services in a timely manner.

Enhanced Housing Transition Services

Eligibility will be based on prioritization status and membership in the target population. Prioritization is based on custom tool factoring length of homelessness, chronicity, and vulnerability factors including mental illness and physical disabilities. When someone is in the top tier, or Priority 1, they are connected with Enhanced Housing Transition services for navigation, document preparation, housing locator services, and services that support a member's ability to prepare for and transition to housing. Specific transition services will include:

• Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.

• Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
• Assisting with the housing application process. Assisting with the housing search process.

• Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.

• Ensuring that the living environment is safe and ready for move-in.

• Assisting in arranging for and supporting the details of the move.

• Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

Program Start: Clients will be enrolled in enhanced Housing Transition services when they have been identified as high-priority for permanent supportive housing by Coordinated Entry, HOT, or RTCN staff. HSA eligibility workers will ensure enrollment in cash and nutrition benefits, and housing navigators will assist with housing unit identification, making and keeping housing appointments, getting documents such as ID

and income verification, and securing other needed items for move-in. Housing Transition Services will collaborate closely with housing providers' on-site teams to assist with housing stabilization and retention.

Program End: Enhanced Housing Transition services will discontinue when a client has successfully moved into housing and has been added to the on-site or mobile team provider's caseload for tenancy stabilization. Services may also be discontinued if a client has left the program voluntarily, or if a client cannot be contacted. If a prioritized client loses contact, then returns, she or he will be added back to the caseload. Membership will be verified on a monthly basis. Services will typically last between 30 and 90 days.

Numbers: HSH projects assisting approximately 250 people per month with housing navigation and benefits eligibility, and that 80% of those will be 200 WPC members.

Housing Transition services will employ the following staff:

Adult Housing Programs Manager (.5 FTE) will provide oversight for all Transitions staff, except for the HSA workers, whose supervision takes place at HSA.

The HSA Eligibility Workers (2 FTE) will be responsible for individual client enrollment and continuing eligibility services for county assistance programs.

The Intake, Assessment, and Navigation staff (5 FTE) will assist homeless clients in preparing rental documents and identification, seeking housing that meets client needs, completing applications, and providing other housing preparation services.

The housing placement and oversight staff (3 FTE) will work directly with housing providers to identify coordinated entry units, classify eligibility requirements, and notify Navigation staff of readiness. They will also work closely with shelter and Navigation Center staff, and HSA eligibility, to notify eligible clients when a unit is available.

Annual rate for the Enhanced Housing Transition Services PMPM is calculated in table below:

ENHANCED HOUSING TRANSITION SERVICES PMPM							
Adult Housing Programs Manager (x0.5)	$ 65,610	$ 109,350	$ 65,610	$ 65,610	$ 306,180	
Adult Housing Programs Manager Fringe (x0.5)	$ 26,244	$ 43,740	$ 26,244	$ 26,244	$ 122,472	
HSA Senior Eligibility Workers (x2)	$ 79,792	$ 132,988	$ 79,792	$ 79,792	$ 372,364	
HSA Senior Eligibility Workers Fringe(x2)	$ 31,917	$ 53,195	$ 31,917	$ 31,917	$ 148,946	
Intake, Assessment, Navigation (x5)	$ 195,000	$ 325,000	$ 195,000	$ 195,000	$ 910,000	
Intake, Assessment, Navigation Fringe (x5)	$ 72,150	$ 120,250	$ 72,150	$ 72,150	$ 336,700	
Housing Transitions and Oversight (x3)	$ 156,105	$ 260,165	$ 156,100	$ 156,100	$ 728,470	
					$ 2,925,132	Total Four Year Cost
					200	Members/month
					42	Months
					$ 348.23	**PMPM**

Housing and Tenancy Stabilization Services

San Francisco will bolster and standardize its care coordination resources in supportive housing through Tenancy Stabilization services. The county is poised to bring all properties funded to assist homeless tenants into its Coordinated Entry system, thereby adding significant referral capacity. Adding this volume of new homeless referrals into properties with little existing services staff will require supplemental care coordination and clinical supervision.

Specific Tenancy services will include services that support the member in being a successful tenant and thus able to sustain tenancy.

• Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.

• Education and training on the role, rights and responsibilities of the tenant and landlord.

• Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

• Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.

• Advocacy and linkage with on-site or community resources to prevent eviction when housing is, or may potentially become jeopardized.

• Assistance with the housing recertification process, if applicable.

• Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

• Continuing training in lease compliance, including ongoing support with activities related to household management.

Eligibility: Homeless beneficiaries placed into permanent housing will be eligible for Tenancy Stabilization services.

Program Start: Tenancy Stabilization services will be provided for people moving in to permanent housing, referred through Coordinated Entry. Beneficiaries may be enrolled as soon as a unit is identified and/or a lease is signed.

After move-in, care coordination (with supervision for services delivery) will continue throughout tenant stabilization. Services will continue through housing stabilization. Services will end if the tenant no longer needs assistance within the housing site, or when she or he moves away from the housing site and no longer needs assistance. Tenancy Stabilization will not overlap with the other services in a foreseeable manner, except at the initial point of enrollment, and before housing placement, at which point a client could be staying at a Navigation Center.

Expected Length of Stay: Housing Stabilization service providers will work with clients for an average of 12-24 months after placement.

Program End: Tenants may choose to discontinue services if there are adequate on-site services to provide ongoing support needed, or if the tenant no longer needs the higher level of support offered under WPC.

Numbers: Once in housing, HSH will work with its partners to provide assistance at a 1/25 staff to client ratio. For 700 WPC members per month, this will require 20 new FTE. Tenancy Stabilization services will be provided for an average of 12-24 months after placement. As people transition off of assistance, new tenants will be added.

Housing & Tenancy Stabilization services will include the following staffing pattern:

Clinical Supervisors (4 FTE) will ensure quality services delivery and will provide oversight for all tenancy stabilization staff. Each Clinical Supervisor will oversee 4-8 Tenancy Stabilization staff.

Partnership Housing Stabilization services provide additional support for people with serious mental illnesses, including community-building, cultural support, activity planning, and educational support. These services are distinct from intensive case management or other services that are billable under current Medi-Cal rules.

Housing &Tenancy Stabilization CM (16 FTE) will provide supportive services and care coordination for up to 700 WPC members placed into permanent housing. Annual rate for the Housing and Tenancy Stabilization PMPM is shown in table below:

HOUSING TENANCY STABILIZATION PMPM						
Clinical Supervisors (x4)	$ 130,285	$ 282,285	$ 325,714	$ 325,714	$ 1,063,998	
Clinical Supervisors Fringe (x4)	$ 48,205	$ 104,445	$ 120,514	$ 120,514	$ 393,678	
Partnership Housing Stabilization	$ 364,285	$ 789,285	$ 910,714	$ 910,714	$ 2,974,998	
Housing Stabilization CM (x16)	$ 713,142	$ 1,545,142	$ 1,782,857	$ 1,782,857	$ 5,823,998	
Housing Stabilization CM Fringe (x16)	$ 263,862	$ 571,670	$ 659,650	$ 659,650	$ 2,154,832	
					$ 12,411,504	Total Four Year Cost
					700	Members/month
					42	Months
					$ 422.16	**PMPM**

Pay for Reporting and Outcomes

Our justification for our metrics selection and outcomes is subsequently described.

Reporting

The Pay for Reporting model of $350,000 per annual reporting period through all project years applies to three universal metrics and one variant metric– V1 and other variant: Housing Services.

Housing Services measures the percent of homeless receiving housing services in PY that were referred for housing services. Transition staff will provide direct referrals to on-site services providers. This metric will test the effectiveness and follow-through of these referrals. This will encourage referring providers to follow up with an-site teams...

Eight metrics – universal metrics 1, 2, 3, 4 and variant metrics 2, 3, 4, 5 – are considered outcome metrics. To ensure accurate reporting of this more complex data affecting health, their pay for reporting model is $500,000 per annual reporting period throughout all project years.

The deliverables for round 2 reporting metrics are the semiannual and annual reports submitted to DHCS with payment of $175,000 per metric per report for a total of $350,000 per year. If only one report is required for PY2 (Jul 1 – Dec 31, 2017), then we will get full payment for the single report.

Round 2 Pay for Reporting Metric	**PY 2 Funds**	**PY 3 Funds**	**PY 4 Funds**	**PY 5 Funds**
Supportive Housing	**$350,000**	**$350,000**	**$350,000**	**$350,000**
Housing Care Coordination	**$350,000**	**$350,000**	**$350,000**	**$350,000**
Coordinated Entry Assessment	**$350,000**	**$350,000**	**$350,000**	**$350,000**
Encampment to Placement Days	**$350,000.**	**$350,000**	**$350,000**	**$350,000**
Housing Services	**$350,000**	**$350,000**	**$350,000**	**$350,000**

Outcomes

Total of eleven metrics (six from round one and five new in round two) – universal 1, 2, 3, 4, variant 2 and "outcome metrics," Medi-Cal Gap Analysis, TB outcome, supportive housing, Encampment to Placement, coordinated entry assessment and housing care

coordination– are considered to impact health in such a way that pay for achievement is warranted. Proposed payments per metric for outcome payments begin at $20,000 in PY2 and grow to $170,000 in PY5. Proposed payments also reflect the PRIME structure of transitioning over time to a higher share of pay-for-outcomes. This approach emphasizes the development of high-quality data and reporting capability at the beginning of the pilot project, then a greater focus on outcomes once data development is complete. The additional three outcome metrics related to supportive housing, housing care coordination, and coordinated entry assessment are structured as $20,000 in PY2 and increase to $90,000 in PY5. The benchmarks for achieving these additional outcome payments are to maintain a baseline in PY2 and *increase* compared to baseline by 5% in PY3, 10% in PY5 and 15% in PY5. The additional Rapid Targeted Coordination and Navigation and Medi-Cal Gap Analysis outcome metric are also proposed as $20,000 in PY2 and increase to $90,000 in PY5. However, the Rapid Targeted Coordination and Navigation benchmark is to maintain baseline at PY2 and decrease compared to baseline by 5% in PY3, 10% in PY4 and 15% in PY5. In the event that we achieve partial progress towards our benchmarks for the new "other outcome" metrics added in round 2, then payment will be commensurate with improvement achieved (e.g., if we reach our goal by 90% then we will be paid 90% of the outcome payment), with maximum reduction being 50% payment for achieving our goal by 50% of the target.

Supportive Housing: Measures the percent of homeless people receiving supportive housing of those who identified as high needs for supportive housing. It is critical to ensure the people with the highest needs are being prioritized for supportive housing. Historically, many high-needs clients have not been accepted into housing because they are more complicated and may take longer to get through the process. Achieving this metric will mean that highest needs people are no longer homeless, enabling better connections to care.

Housing Care Coordination: Measures the number of formerly homeless residents of supportive housing who identified for enhanced care coordination. It is instrumental in understanding the needs of the formerly homeless people in housing, and identifying the formerly homeless people with the highest needs. Encourages higher levels of care for higher needs, if housing is the result.

Common Assessment for Coordinated Entry: Measures the number of homeless people assessed using the universal assessment tool. This metric will be instrumental in understanding the needs of the homeless people in the community and identifying the homeless people with the highest needs. It encourages a quick and standardized process for getting assessments done, thus shortening the path to housing.

Encampment to Placement Days: Measures the number of days from the time the Encampment to Placement Team initially engages residents of a tent encampment to the time when all residents have been offered shelter, navigation center, housing, or

other placement. Instrumental in planning how many encampment residents can be assisted each year, and allocating needed resources accordingly. Encourages the team to assist people into housing paths as quickly as possible.

The benchmarks for achieving outcome payments for U1 and U2 are to maintain baseline in PY2 and *decrease* compared to baseline by 3% in PY3, 6% in PY4 and 9% in PY5. Conversely, the benchmarks for achieving outcome payments for U3 and U4 are to maintain baseline in PY2 and *increase* compared to baseline by 3% in PY3, 6% in PY4 and 9% in PY5. The benchmark for achieving outcome payments for V2 and TB clearance is to maintain baseline in PY2 and *increase* compared to baseline by 5% in PY 3, 10% in PY 4, and 15% in PY 5.

Our overall strategy for outcome payments is to start with smaller nominal payments as care providers begin to use these new metrics. Payments increase as we learn how to better to improve outcomes for our clients.

Round 2 Outcome Metrics	**PY 2 Funds**	**PY 3 Funds**	**PY 4 Funds**	**PY 5 Funds**
Supportive Housing	**$25,000**	**$68,750**	**$112,500**	**$112,500**
Housing Care Coordination	**$25,000**	**$68,750**	**$112,500**	**$112,500**
Common Assessment for Coordinated Entry	**$25,000**	**$68,750**	**$112,500**	**$112,500**
Encampment to Placement Days	**$25,000**	**$68,750**	**$112,500**	**$112,500**

Metrics Justification

Measure	**What is measured**	**Why measured**	**Source**	**Pay for:**
Universal Metrics				
U1. Emergency Department Utilization	During reporting period: # medical and psy ED visits by WPC enrollees / # WPC enrollees using ED	Required. Also, the average is high -- 5.8 ED visits per ED user in target population.	HEDIS	Reporting and Outcome

Measure	What is measured	Why measured	Source	Pay for:
U2. Inpatient Hospital Utilization	During reporting period: # of hospital admissions and # of days / # of WPC enrollees being hospitalized	Required. Target population inpatient users average 13.6 days annually.	HEDIS	Reporting and Outcome
U3. Follow up after hospitalization for Mental Illness	During reporting period: # of hospitalized WPC enrollees receiving follow-up / # hospitalized WPC enrollees	Required. Nearly 50% of target population suffers from mental health disorders.	HEDIS	Reporting and Outcome
U4. Initiation and engagement of alcohol and other drug dependency	During reporting period: # WPC enrollees using residential AOD detoxification who enroll in other treatment following detox / # WPC enrollees in detox	Required. 50% of target population has alcohol diagnosis.	HEDIS	Reporting and Outcome
U5. Proportion of beneficiaries with care plan accessible by entire team w/in 30 days of enrollment and anniversary in program	During reporting period: # of WPC enrollees in psych ED and Inpt receiving MH follow-up treatment who have care plans / # WPC enrollees in psych ED and Inpt.	Required. Treatment plan improves care, reduces duplication and harm.	Process	Reporting
U6. Care coordination, case management, and referral infrastructure	Reports on procedures for coordination and referrals among partners	Required. Expand policy and procedure to cover expanded population. Improves monitoring and governance	Process	Reporting
U7. Data and information sharing infrastructure as measured by	Reports on data sharing progress shown by development of	Required. Partner agencies have baseline	Process	Reporting

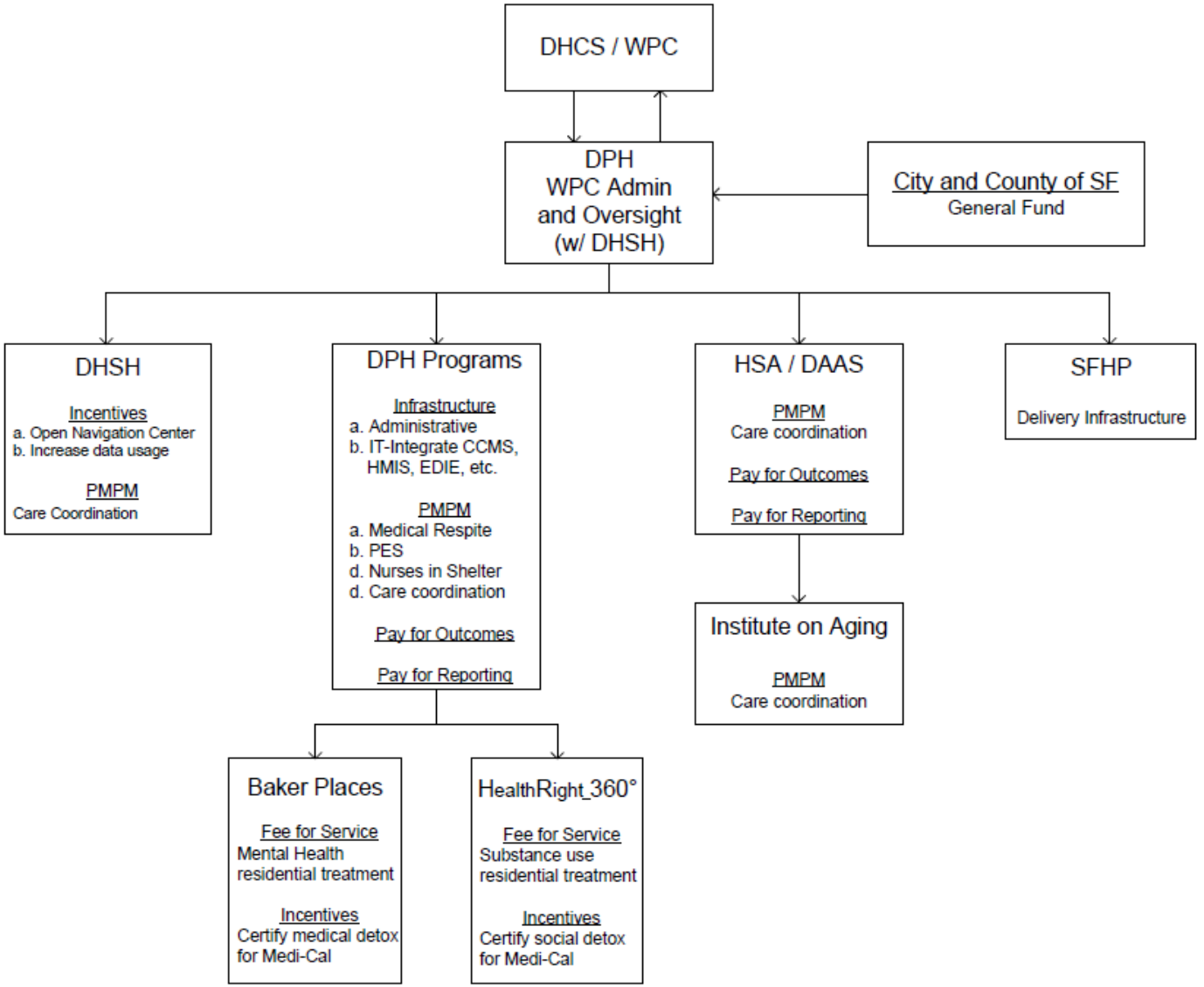
Measure	**What is measured**	**Why measured**	**Source**	**Pay for:**
documentation of policies and procedures for all entities that provide care coordination, case management monitoring, strategic improvements.	infrastructure, policies, reports, case plans, monitoring of operations	policies and procedures.		
Variant Metrics				
Measure	**What is measured**	**Why measured**	**Source**	**Pay for:**
1. Completion of Universal Assessment Tool with homeless individuals	Health assessment is part of planned universal tool. This records completion of this shared data item.	Variant. Population carries high risk for escalating health costs.	Admin	Reporting
2. Health Outcomes: 30 day All Cause Readmissions	count of hospital readmissions w/in 30 days of previous discharge	Required Variant.	Health	Reporting and Outcome
3. Health Outcomes: Decrease Jail Recidivism	count of jail incarcerations over time period	Required Variant.	Health	Reporting
4. Health Outcomes: Suicide Risk Assessment Required for Pilots w/ SMI Target Population	count of suicide assessments in PES and Psych Inpatient	Required Variant.	Health	Reporting
5. Housing: Permanent Housing	measures the number of persons who achieve a 6 month milestone in their housing placements	Required Variant.	Housing	Reporting

Outcome Metrics				
Measure	**What is measured**	**Why measured**	**Source**	**Pay Type**
TB clearance in preparation for next treatment placement	Measures number of homeless persons with TB clearance ready for next placement	Critical to transitioning to other services	Outcome	Outcome
Supportive Housing	Measures the percent of homeless referred for supportive housing who receive supportive housing.	Critical to ensure the people with the highest needs are being prioritized for supportive housing.	Housing	Reporting
Housing Care Coordination	Measures the number of formerly homeless residents of supportive housing who identified for enhanced care coordination.	Instrumental in understanding the needs of the formerly homeless people in the housing, and identifying the formerly homeless people with the highest needs.	Process	Reporting
Common Assessment for Coordinated Entry	Measures the number of homeless people assessed using the universal assessment tool.	Instrumental in understanding the needs of the homeless people in the community and identifying the homeless people with the highest needs.	Process	Reporting
Encampment to Placement Days	Measures the number of days from the time the Encampment to Placement Team initially engages residents of a tent encampment to the time when residents have been offered	Instrumental in planning how many encampment residents can be assisted each year, and allocating needed resources accordingly.	RTCN reports by date	Reporting

Outcome Metrics				
	shelter, navigation center, housing, or other placement.			
Housing Services	Measures the percent of homeless receiving housing services in PY that were referred for housing services	Vital to ensuring follow-through on services referrals and ongoing support for clients.d6	Process	Reporting

5.2 Funding Diagram Attachment

San Francisco Proposed Funding Diagram for Whole Person Care Pilot



WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	City and County of San Francisco

Annual Budget Amount Requested	**Federal Funds** *(Not to exceed 90M)*	**IGT**	**Total Funds**
	18,050,000	**18,050,000**	**36,100,000**

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	23,600,000
Approved Application (75%)	17,700,000
Submission of Baseline Data (25%)	5,900,000

PY 2 Budget Allocation	
PY 2 Total Budget	29,850,000
Administrative Infrastructure	853,243
Delivery Infrastructure	3,632,020
Incentive Payments	2,125,000
FFS Services	3,530,632
PMPM Bundle	11,989,105
Pay For Reporting	7,500,000
Pay for Outomes	220,000

PY 3 Budget Allocation	
PY 3 Total Budget	36,100,000
Administrative Infrastructure	1,425,993
Delivery Infrastructure	3,122,311
Incentive Payments	1,440,000
FFS Services	7,107,012
PMPM Bundle	14,809,684
Pay For Reporting	7,500,000
Pay for Outcomes	695,000

PY 4 Budget Allocation	
PY 4 Total Budget	36,100,000
Administrative Infrastructure	1,437,197
Delivery Infrastructure	1,840,593
Incentive Payments	1,320,000
FFS Services	7,430,827
PMPM Bundle	15,401,383
Pay For Reporting	7,500,000
Pay for Outomes	1,170,000

PY 5 Budget Allocation	
PY 5 Total Budget	36,100,000
Administrative Infrastructure	1,458,689
Delivery Infrastructure	1,830,129
Incentive Payments	430,000
FFS Services	7,430,827
PMPM Bundle	15,980,354
Pay For Reporting	7,500,000
Pay for Outomes	1,470,000